EDICAL CARE STATISTICS SECTION
Department of Health Services

MANAGED CARE ANNUAL STATISTICAL REPORT

Published June 2003

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal beneficiaries. It provides information on the number of persons enrolled in managed care, and a description of some of the demographic and eligibility characteristics of this population.

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Introduction

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal eligibles. It also gives a description of the types of programs providing managed care services to Medi-Cal beneficiaries, the number of persons enrolled, and a description of some of the demographic and eligibility characteristics of this population.[1]

The Managed Care Annual Statistical Report does not present cost or utilization information for the Medi-Cal managed care population. Cost data for this population, as well as those in Fee-For-Service (FFS), are available in the Annual Statistical Report issued by this Section. Managed care utilization information is currently limited but will become available at a future date from the State Department of Health Services (DHS). Detailed information about dental managed care can be obtained from the DHS Payment Systems Division, Office of Medi-Cal Dental Services.

Please note the source for the enrollment and demographic charts and graphs in this report is the Monthly Medi-Cal Eligibles File, produced each month by the Department of Health Services. Eligibility data from this file for a previous month of eligibility was used to allow retroactive eligibles to be posted. In most cases, the month of eligibility for July 2002 was used from the file created late December 2002.

Other information related to Medi-Cal managed care is available on the DHS Medical Care Statistics Section (MCSS) website. The report entitled "Report on the Use of Medi-Cal Managed Care Encounter Data for Research Purposes," issued January 2002 (found under "Publications" on the MCSS website) reviews the quality and completeness of managed care encounter data. Current and historical counts of managed care beneficiaries by different variables are available in the "Beneficiary Data Files" section of the MCSS website.

[1] The terms "eligible," "beneficiary," and "enrollee" are used interchangeably within Medi-Cal. Each refers to a person who meets all requirements for receiving a Medi-Cal medical service or good (e.g., drugs, DME items) and is enrolled in the Medi-Cal program. These terms are differentiated from the term "user," who is a beneficiary actually receiving a service, drug, or DME item, etc.

Section 1, History and Description of Medi-Cal Managed Care

Prior to 1994, Medi-Cal had predominately used a FFS health care delivery system to provide care to its beneficiary population. Under this system, qualified providers render care or provide all covered services such as physician services, drugs, and durable medical equipment (DME) items to beneficiaries, then bill the State; upon adjudication of their claims for services, the providers are paid the Medi-Cal approved rate.

The State believed that converting to a managed care system based on preventive and primary care would provide better health care for Medi-Cal beneficiaries. Managed care is a planned, comprehensive approach to the provision of health care combining clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in an effective manner. Under managed care, individual providers are linked together into a system that formalizes the often-informal provider relationships that exist under FFS and brings them together under a single entity, the managed care plan. The plan manages the links and is accountable for performance and outcomes. Managed care's emphasis on access to primary care is intended to increase utilization of clinical preventive services and thus reduce both preventable hospitalizations and the unnecessary use of emergency rooms. In turn, this enables the plan to reallocate its resources to promote preventive and primary care for its members.

Section 1.1, History of Medi-Cal Managed Care

The State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972 Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category. In June 1983, a new type of managed care program, the County Organized Health System (COHS), began covering Medi-Cal beneficiaries when the Monterey Health Initiative became operational. This program stressed case management and utilization control in the delivery of health services to Medi-Cal eligibles. A few months later, in September 1983, the Santa Barbara Health Initiative also began operating a COHS. Both were similar in that almost all beneficiaries in the county were mandated to join the plan. Whereas the Monterey program stressed local control Primary Care Case Management (PCCM), Santa Barbara stressed centralized utilization control. The Monterey COHS ceased operations in July 1985 and has since been replaced with the Central Coast Alliance for Health, which covers both Monterey and Santa Cruz counties. A third COHS, the Health Plan of San Mateo, began operations in December 1987.

In August 1984, a third Medi-Cal managed care program began operation, the PCCM program. Like the PHP program, enrollment in PCCM plans was voluntary. The PCCMs were responsible for outpatient services only. Inpatient services for PCCM enrollees were delivered through the FFS program. The PCCM stressed assignment of

a personal physician to each beneficiary in the plan, and that physician authorized virtually all other services delivered by the PCCM plan.

State legislation in 1991 and 1992 enabled a substantial expansion of Medi-Cal managed care, primarily for AFDC-linked eligibles.[2] Pursuant to this legislation, the Department of Health Services (DHS) started the process of developing and implementing a Geographic Managed Care (GMC) program in two counties, a Two-Plan Model program in twelve counties, and the COHS program in three additional counties. (See Appendix, Table A.1 for a list of the aid categories each of these plans cover.) In addition, a Special Project referred to as the Medi-Cal Fee-For-Service Managed Care Program (FFS-MC) began operations in the counties of Sonoma and Placer in March and October 1997, respectively.

The 1991 managed care legislation was significant in that prior to 1991 in a county in which Medi-Cal managed care plan enrollment was available, beneficiaries who did not choose between FFS and a plan were defaulted into FFS. With the 1991 legislation, the state was allowed under specific circumstances to direct the defaults into managed care.

Section 1.2, Description of Medi-Cal Managed Care

Before 1994, there were three managed care programs providing medical care to the Medi-Cal population, the PHP program, the PCCM program, and the COHS program. From 1994 forward, two more programs were developed and implemented, the GMC program and the Two-Plan Model program. In 1995 and 1996, three additional counties formed COHS organizations. Currently, there are four managed care programs enrolling Medi-Cal eligibles: PHPs (full capitation, voluntary), COHSs (most aid categories, mandatory), GMC plans (Managed Care Family aid categories, mandatory) and Two-Plan Model plans (Managed Care Family aid categories, mandatory). There is only one PCCM program enrolling Medi-Cal eligibles as of June 2002. The following describes each of these programs.

Prepaid Health Plan

The State Waxman-Duffy Act authorized Health Maintenance Organization (HMO) contracting in the Medi-Cal Program and referred to such plans as PHPs. In California, the PHP contracting program was established as an alternative to FFS. The intent of the program was to provide the Managed Care Family aid categories Medi-Cal beneficiaries

[2] Other terms and programs, pursuant to recent Federal and State legislation, are replacing the term Aid to Families with Dependent Children (AFDC). For example, some persons formerly on AFDC are now on California's CalWorks' (made possible by Section l93lb of Title XIX of the Social Security Act), which implements the "Federal Temporary Assistance to Needy Families" (TANF) program. Other formerly AFDC eligibles are referred to as eligible under Section l93lb of Title XIX of the Social Security Act. What was formerly referred to as AFDC is referred to in this report as "Managed Care Family" aid categories.

who enrolled to have access to health care generally available in the public sector. PHPs are required to provide, on a capitated, at-risk basis, all basic Medi-Cal covered benefits, excluding such specified treatments as major organ transplants, chronic renal dialysis and long term care. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classifications.) In addition, PHPs provide case management, preventive and health maintenance services. As managed care contractors, PHPs have other requirements not found in FFS, such as quality of care management, membership services, and member grievance procedures. DHS administers the contracts with the PHP contractors and the Department of Managed Health Care oversees their operations as commercial health plans under the Knox-Keene Act. As of June 2002, beneficiaries in PHPs comprise 0.01% of all Medi-Cal beneficiaries, or about 900 members per month.

Primary Care Case Management

The PCCM program is a managed care model that covers outpatient, physician, and some other outpatient services. PCCMs exclude inpatient services and some outpatient services from the scope of benefits provided under their capitated contracts. Under PCCM arrangements, primary care providers contract with DHS as managed care plans to provide and assume risk for primary care and specialty physicians' services as well as selected outpatient preventive and treatment services. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classifications.) PCCM contractors are required to case manage all services provided to their enrollees. Contractors participate in program savings through savings-sharing agreements with DHS. Shared savings must be produced by the PCCM's effective case management of services for which the PCCM is not at risk, the most significant of which is inpatient hospital care.

PCCM contracts operate under DHS review and oversight. Although PCCMs have not been directly subject to either the Knox-Keene or Waxman-Duffy Prepaid Health Plan Act, many of the relevant requirements are reflected in these contracts. Due to the implementation of the mandatory managed care programs, only one PCCM remains in operation, Positive Healthcare in Los Angeles county. As of June 2002, beneficiaries in this PCCM comprise 0.01% of all Medi-Cal beneficiaries, or about 680 members per month.

Geographic Managed Care

Sacramento County was selected for the development of a GMC program in early 1992, and the program began enrolling in April 1994. Initially, under Sacramento GMC, DHS contracted with seven managed care health plans for medical services and four dental care plans for dental services. Five of the seven plans were fully-capitated PHP plans and two were PCCMs.

The California Medical Assistance Commission negotiates capitation rates on behalf of DHS with each plan; rates are kept confidential. The mandatory aid category groups are: Managed Care Family aid categories, medically needy with no share of cost, medically indigent adult (confirmed pregnancy), medically indigent children, and percent-of-poverty children. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classification.) Medi-Cal beneficiaries allowed to join voluntarily include those who are in a Supplemental Security Income (SSI) or foster child aid category or who otherwise meet certain medical exemption criteria. Beneficiaries enrolled with a commercial or Medicare HMO are not allowed to enroll. In addition, eligibles in a mandatory aid category will not be enrolled in a plan during the months of retroactive eligibility or for the two months while they decide into which plan they want to enroll.

DHS received waivers of federal requirements for freedom of choice that permitted provision of Medi-Cal benefits to this population exclusively through GMC managed care plans. State legislation in 1994 permitted a second GMC program, referred to as "Healthy San Diego," to be formed in San Diego county. Enrollment began in mid-1998.

Under GMC, covered beneficiaries are informed about the available managed care plans and then are asked to select a plan. Beneficiaries are assisted in the selection process through the involvement of a Health Care Options (HCO) contractor, who provides them a presentation and explanatory materials about each of the plans. If a beneficiary does not select a plan, he/she is assigned to one.

Currently, there are five comprehensive plans in Sacramento county and seven in San Diego county that cover inpatient and all other medical services. DHS directly contracts with each of these GMC plans. As of June 2002, beneficiaries in GMCs comprise 5.5% of all Medi-Cal beneficiaries, or about 335,170 members per month.

County Organized Health Systems

Under the COHS model, a county board of supervisors to contract with the Medi-Cal program creates a local agency, with representation from providers, beneficiaries, local government, and other interested parties. Operating under federal Medicaid freedom of choice and other waivers, the COHS administers a capitated, comprehensive, case managed health care delivery system. They are responsible for utilization control and claims administration, and must provide most Medi-Cal covered health care services. COHSs are health insuring organizations which manage and pay for services but do not directly provide care. Virtually all Medi-Cal beneficiaries with legal residency in the county must belong to the COHS. (Medi-Cal beneficiaries who are in recently established aid categories may not be covered due to a lack of historical data upon which to establish capitation rates.) Beneficiaries are given a wide choice of providers but do not have the option of obtaining Medi-Cal services under the traditional FFS system except for those services excluded from coverage, e.g., long term care (one plan only). Like the GMC program, the California Medical Assistance Commission negotiates capitation rates for each plan, except the Santa Barbara Health Initiative; these rates are also kept confidential.

Three COHSs operated in the 1980's in the counties of Monterey, Santa Barbara, and San Mateo. Monterey ceased operations in 1985. Enabling State legislation and federal HCFA waiver approvals later permitted three additional counties to form COHSs. The Solano Partnership Health Plan began operations in May 1994 and became Partnership HealthPlan of California in March 1998, when Napa county was added. In October 1995, the California Orange Prevention and Treatment Integrated Medical Assistance Plan (CalOPTIMA) started enrolling Medical beneficiaries. In January 1996, the Santa Cruz County Health Options began operations; when Monterey county joined Santa Cruz in October 1999, the plan changed its name to Central Coast Alliance for Health. Yolo county joined the Partnership HealthPlan of California in March 2001.

COHSs currently exist in Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano and Yolo counties. The Partnership HealthPlan of California is expected to expand into Marin County by 2004. As of June 2002, beneficiaries in COHSs comprise 8.41% of all Medi-Cal beneficiaries, or about 512,600 members per month.

Two-Plan Model

A plan for a new type of Medi-Cal managed care program was developed by DHS and a report was issued March 31, 1993 entitled Expanding Medi-Cal Managed Care. Under this program, two HMO plans operate in each of the selected counties. One is operated under the auspices of the county government or a community based entity, e.g., an independent health commission; the other is a commercial HMO selected by DHS through competitive bid. The two plans are directly monitored by DHS and have the same contract requirements. The publicly sponsored plan is referred to as the local initiative (LI), and the private HMO as the commercial plan (CP). It was envisioned that the LI would provide a means for hospitals, clinics, and physicians who traditionally cared for Medi-Cal beneficiaries under FFS, as well as the safety net providers who provide care to both Medi-Cal beneficiaries and other medically indigent persons, to continue providing these services under managed care. In the case of hospitals, this arrangement helps support receipt of federal disproportionate share hospital funds. Contract provisions also promote use of cultural and linguistic services for those beneficiaries needing them. Both the LI and CP plans provide full medical services, including inpatient, and must be Knox-Keene licensed. Contract rates are established by DHS.

The mandatory aid category groups are: Managed Care Family aid categories, medically needy with no share of cost, medically indigent adult (confirmed pregnancy), medically indigent children, and percent poverty children. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classification.) Those allowed to join voluntarily include those who are in an SSI or foster child aid category or who meet certain medical exemption criteria.

The counties selected by DHS for the Two-Plan Model initially included Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Subsequently, San Diego was legislatively chosen to implement the GMC program (see above). Fresno chose not to implement a local initiative, thereby resulting in DHS selecting a second commercial plan for that county. The commercial plan in Stanislaus county ceased operations in March 2000; as a result, beneficiaries in mandatory aid codes were allowed to elect to enroll into the remaining local initiative or FFS; if a beneficiary did not make a selection, they were defaulted into the local initiative. As of June 2002, beneficiaries in Two-Plan model plans comprise 37.78% of all Medi-Cal beneficiaries, or about 2,303,840 members per month.

Special Projects

DHS is developing new types of managed care programs for Medi-Cal beneficiaries. These managed care programs strive to promote improved health status and to avoid non-duplicative or otherwise unnecessary costs. Two types of special projects currently implemented in DHS are:

Medical Case Management of Populations with Special Health Care Needs -- DHS has established other programs to manage high-cost Medi-Cal beneficiaries within the FFS environment. Under this program, DHS develops and conducts pilot projects under which these populations receive medical case management. Examples include those with AIDS and the elderly at risk of entering long-term care, e.g., On Lok and Scan Health plans

Fee-For-Service Managed Care (FFS-MC) -- To improve the coordination of care for those beneficiaries in FFS and to improve continuity of care, DHS established fee-for-service, “gatekeeper model” managed care programs in Sonoma and Placer Counties, starting March and October 1997, respectively. This program pays the contracted local government a fee per eligible per month for: 1) establishing a primary care physician network from which beneficiaries select or are assigned to a personal physician; and 2) case managing the services received by the Medi-Cal beneficiaries, thereby improving coordination of care. The FFS-MC waiver program will be terminating effective June 30, 2003. Beneficiaries will be rolled into straight Fee-for-Service Medi-Cal.

As of June 2002, beneficiaries in Special Projects comprise 0.54% of all Medi-Cal beneficiaries, or about 33,100 members per month.

Scope of Services Covered by Managed Care

The scope of services covered by Medi-Cal managed care health plans is determined by their contract with DHS. Comprehensive plans typically cover inpatient care, limited skilled nursing services, and most outpatient services. Exceptions may vary from plan to plan and between managed care models. Plans are required to provide all medically necessary care, but may restrict such coverage to no more than what Medi-Cal would cover or may expand the coverage provided. Plans are not required to cover some services such as Psychiatric and AIDS drugs. Carved out services are listed in the EDS (FFS) Provider Manuals, available at http://www.medi-cal.ca.gov/, or can be obtained by calling the DHS Medi-Cal Managed Care Division.

Section 1.3, Enrollment Statistics for Medi-Cal Managed Care

Enrollment in Medi-Cal managed care plans rose sharply in the mid-1990's and currently is close to 52% of total Medi-Cal eligibles. Table 1.1, Medi-Cal Eligibles by Program FFS vs. Managed Care Programs, shows how the relative number of beneficiaries in the various managed care plans as well as FFS has remained unchanged since early 2000, but all numbers have increased as the total Medi-Cal population has grown.

As shown in Table 1.2, Map of California's Managed Care Counties, Medi-Cal managed care is now in twenty-four of California's fifty-eight counties, excluding the small Kaiser PHP in Marin County. Tables 1.3A and 1.3B, Medi-Cal Managed Care Plans by County, list the different plans by name and county of service along with other pertinent information, such as current enrollment figures.

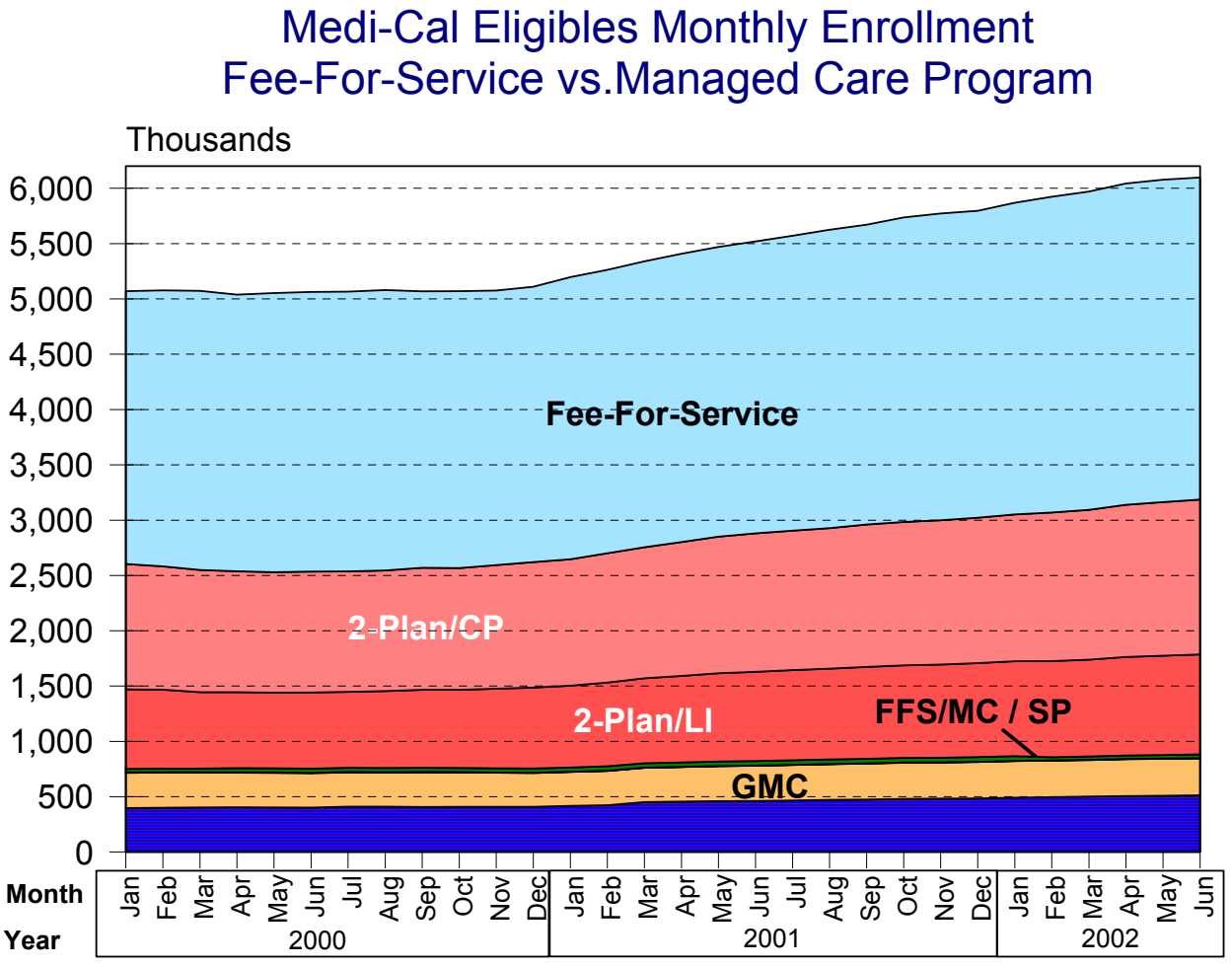
Table 1.4, Monthly Enrollment for Two-Plan Counties, illustrates that enrollment for these managed care plans has been very stable since early 2001. In every county where there is both a local initiative and commercial plan, the former has more members. Table 1.5, Monthly Enrollment for GMC Counties, shows how one to two plans in Sacramento and San Diego counties have predominately most of the members. However, one of the two plans common to both counties, Blue Cross of California, is a dominant plan in Sacramento, but a relatively minor plan in San Diego.

Analyses of the composition of the managed care plans versus FFS in terms of mandatory Medi-Cal aid code categories follow in Tables 1.6 through 1.8. Table 1.6, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties, provides aggregated counts for the Two-Plan and GMC versus the COHS counties, and Table 1.7, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties, provide these breakouts by county. Lastly, Table 1.8, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles in GMC and Two-Plan Model Counties Only, illustrate how, in most cases, 80 to 90% of the mandatory aid code category beneficiaries actually end up in one of these managed care plans. The narrative for this table lists nine of the most common reasons for this occurrence.

Table 1.1, Medi-Cal Eligibles by Program – FFS vs. Managed Care Programs

The following graph shows the monthly enrollment (January 2000 forward) in Medi-Cal for medical FFS and managed care plans. Each type of managed care program is shown separately. Total June 2002 enrollment was: FFS – 2,911,898; COHS – 512,600; GMC – 335,167; Two-Plan/Local Initiative – 903,511; Two-Plan/Commercial Plan – 1,400,325; FFS/MC – 29,430; SP – 3,664; PHP – 902; PCCM – 676.

Source: July 2002 month of eligibility Medi-Cal Eligibles File, using a six-month lag.
FFS/MCN eligible counts source is the Monthly Enrollment Report Provided by the Managed Care Fiscal Monitoring Unit.



Note: By June of 2002 the PHP/PCCM population represent less than one-tenth of one percent (0.026%) of the total Medi-Cal population.

Table 1.2, Map of California's Managed Care Counties

The following map of California shows each county with a managed care plan in operation.
(Note: Excludes PHP and PCCM programs.)

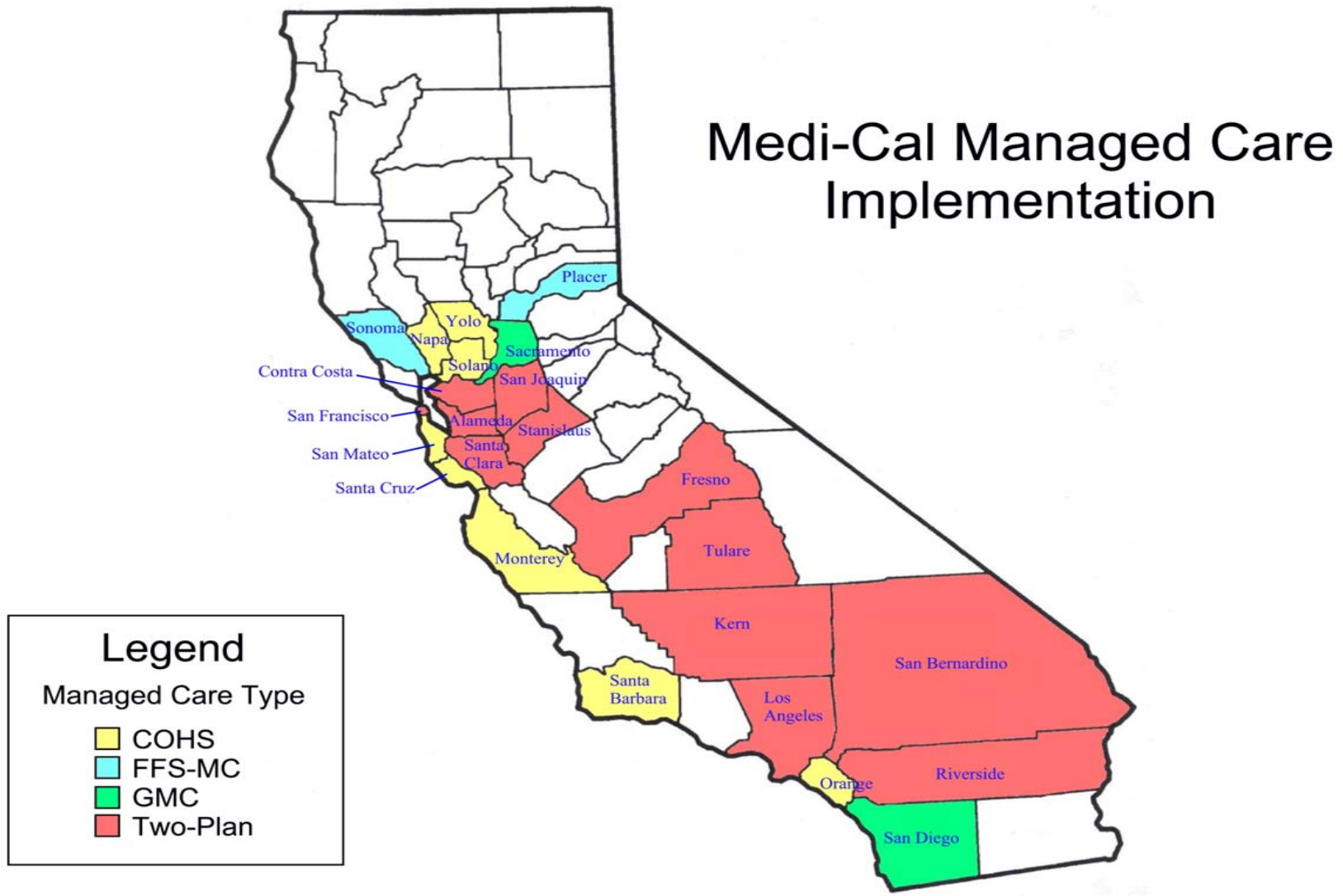


Table 1.3A, Medi-Cal Managed Care Plans by County
Prepared by the California Department of Health Services

The following tables show Medi-Cal managed care plans by county (Table1.3A) and by plan then county (Table 1.3B). The managed care programs included here are: COHS, FFS-MC, GMC, and Two-Plan Model. Excluded are PHP, PCCM, and special projects (e.g., AIDS, SCAN).

Table 1.3A, Medi-Cal Managed Care Plans by County

County	Program	LI/ CP*	Plan Name	Start Date	Enrollment** as of July 2002
Alameda	2-PLAN	LI	Alameda Alliance for Health	1/96	69,449
		CP	Blue Cross of California	7/96	27,145
Contra Costa	2-PLAN	LI	Contra Costa Health Plan	2/97	41,426
		CP	Blue Cross of California	6/98	5,834
Fresno	2-PLAN	CP	Health Net	1/97	29,907
		CP	Blue Cross of California	11/96	124,759
Kern	2-PLAN	LI	Kern Health Systems	7/96	66,918
		CP	Blue Cross of California	9/96	33,932
Los Angeles	2-PLAN	LI	LA Care Health Plan	4/97	798,548
		CP	Health Net	7/97	529,633
Monterey	COHS		Central Coast Alliance For Health	10/99	54,917
Napa	COHS		Partnership Health Plan of California	3/98	9,326
Orange	COHS		CalOPTIMA	10/95	268,987
Placer ***	FFS/MC		Placer County Managed Care Network	10/97	6,726
Riverside	2-PLAN	LI	Inland Empire Health Plan	9/96	92,653
		CP	Molina Healthcare	3/98	36,826
Sacramento	GMC		Blue Cross of California	4/94	73,455
			Health Net	5/96	30,655
			Kaiser Foundation Health Plan	4/94	19,888
			Western Health Advantage	5/97	15,422
			Molina Healthcare	2/00	21,533

Table 1.3A, Medi-Cal Managed Care Plans by County (continued)

Prepared by the California Department of Health Services

County	Program	LI/ CP*	Plan Name	Start Date	Enrollment** as of July 2002
San Bernardino	2-PLAN	LI	Inland Empire Health Plan	9/96	124,944
		CP	Molina Healthcare	3/98	50,210
San Diego**	GMC		Blue Cross of California	7/98	15,658
			Community Health Group	7/98	67,581
			Health Net	7/98	8,882
			Kaiser Foundation	7/98	9,437
			Sharp Health Plan	7/98	49,047
			UCSD Healthcare	7/98	12,986
			Universal Care	7/98	11,979
San Francisco	2-PLAN	LI	San Francisco Health Plan	1/97	27,729
		CP	Blue Cross of California	7/96	14,881
San Joaquin	2-PLAN	LI	Health Plan of San Joaquin	2/96	53,962
		CP	Blue Cross of California	1/97	18,143
San Mateo	COHS		Health Plan of San Mateo	12/87	42,326
Santa Barbara	COHS		Santa Barbara Health Initiative	9/83	48,385
Santa Clara	2-PLAN	LI	Santa Clara Family Health Plan	2/97	55,636
		CP	Blue Cross of California	10/96	23,364
Santa Cruz	COHS		Central Coast Alliance for Health	1/96	24,959
Solano	COHS		Partnership Health Plan of California	5/94	43,245
Sonoma *	FFS/MC		Sonoma Partners for Health Managed Care	3/97	22,764
Stanislaus	2-PLAN	LI	Blue Cross of California/SLI	10/97	27,922
Tulare	2-PLAN	LI	Blue Cross of California	3/99	55,729
		CP	Health Net	2/99	16,889
Yolo	COHS		Partnership Health Plan of California	3/01	22,805

* "LI" stands for Local Initiative; "CP" stands for Commercial Plan.

** Source for number of eligibles for all plans except FFS/MC is the Monthly Medi-Cal Eligibility File.

*** Source for FFS/MC eligible counts is the Monthly Enrollment Report provided by the Managed Care Fiscal Monitoring Unit.

**** The official name for the San Diego GMC is "Healthy San Diego".

Table 1.3B, Medi-Cal Managed Care Plans by County
Prepared by the California Department of Health Services

Plan Name	Program	LI/CP*	County	Enrollment** as of July 2002
Alameda Alliance for Health	2-PLAN	LI	**Alameda**	**69,449**
Blue Cross of California			**TOTAL**	**420,822**
	2-PLAN	CP	**Alameda**	27,145
	2-PLAN	CP	**Contra Costa**	5,834
	2-PLAN	CP	**Fresno**	124,759
	2-PLAN	CP	**Kern**	33,932
	GMC		**Sacramento**	73,455
	GMC		**San Diego****	15,658
	2-PLAN	CP	**San Francisco**	14,881
	2-PLAN	CP	**San Joaquin**	18,143
	2-PLAN	CP	**Santa Clara**	23,364
	2-PLAN	LI	**Stanislaus**	27,922
	2-PLAN	LI	**Tulare**	55,729
CalOPTIMA	COHS		**Orange**	**268,987**
Central Coast Alliance For Health			**TOTAL**	**79,876**
	COHS		**Monterey**	54,917
	COHS		**Santa Cruz**	24,959
Community Health Group	GMC		**San Diego****	67,581
Contra Costa Health Plan	2-PLAN	LI	**Contra Costa**	41,426
Health Net			**TOTAL**	**615,966**
	2-PLAN	CP	**Fresno**	29,907
	2-PLAN	CP	**Los Angeles**	529,633
	GMC		**Sacramento**	30,655
	GMC		**San Diego****	8,882
	2-PLAN	CP	**Tulare**	16,889
Health Plan of San Joaquin	2-PLAN	LI	**San Joaquin**	**53,962**
Health Plan of San Mateo	COHS		**San Mateo**	**42,326**
Inland Empire Health Plan			**TOTAL**	**217,597**
	2-PLAN	LI	**Riverside**	92,653
	2-PLAN	LI	**San Bernardino**	124,944

Table 1.3B, Medi-Cal Managed Care Plans by County (continued)

Prepared by the California Department of Health Services

Plan Name	Program	LI/CP*	County	Enrollment** as of July 2002
Kaiser Foundation Health Plan		**TOTAL**		**29,325**
	GMC		**Sacramento**	19,888
	GMC		**San Diego****	9,437
Kern Health Systems	2-PLAN	LI	**Kern**	**66,918**
LA Care Health Plan	2-PLAN	LI	**Los Angeles**	**798,548**
Molina Healthcare		**TOTAL**		**115,478**
	2-PLAN	CP	**Rverside**	57,739
	GMC		**Sacramento**	15,208
	2-PLAN	CP	**San Bernardino**	42,531
Partnership Health Plan of California		**TOTAL**		**75,376**
	COHS		**Napa**	9,326
	COHS		**Solano**	43,245
	COHS		**Yolo**	22,805
Placer County Managed Care Network	FFS/MC		**Placer*****	**6,726**
San Francisco Health Plan	2-PLAN	LI	**San Francisco**	**27,729**
Santa Barbara Health Initiative	COHS		**Santa Barbara**	**48,385**
Santa Clara Family Health Plan	2-PLAN	LI	**Santa Clara**	**55,636**
Sharp Health Plan	GMC		**San Diego****	**49,047**
Sonoma Partners for Health Managed Care	FFS/MC		**Sonoma*****	**22,764**
UCSD Healthcare	GMC		**San Diego****	**12,986**
Universal Care	GMC		**San Diego****	**11,979**
Western Health Advantage	GMC		**Sacramento**	**15,422**

* "LI" stands for Local Initiative; "CP" stands for Commercial Plan.

** Source for number of eligibles for all plans except FFS/MC is the Monthly Medi-Cal Eligibility File.

*** Source for FFS/MC eligible counts is the Monthly Enrollment Report provided by the Managed Care Fiscal Monitoring Unit.

**** The official name for the San Diego GMC is "Healthy San Diego".

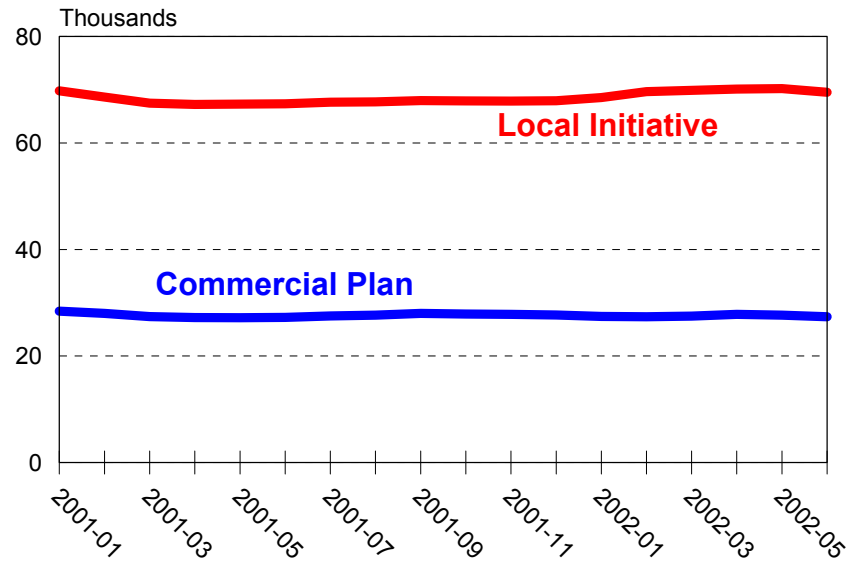
Table 1.4, Monthly Enrollment for Two-Plan Counties

The following charts depict monthly enrollment by county and Commercial Plan vs. Local Initiative for January 2001 thru June 2002. As these charts show, in most counties, the Local Initiative has more Medi-Cal beneficiaries than the Commercial Plan. On a statewide basis, the Local Initiative plans have two to three members for every one in the Commercial Plans. This may be explained by the fact that the Local Initiative was implemented before the Commercial Plan. Contra Costa county is an exception, averaging four members enrolled in the Local Initiative for every one in the Commercial Plan. The Fresno county model has two Commercial Plans and no Local Initiative. The enrollment between the two plans is four members in Blue Cross of California for every one in Health Net. Stanislaus county has had only a Local Initiative since March 2000, when the Commercial Plan ceased operations.

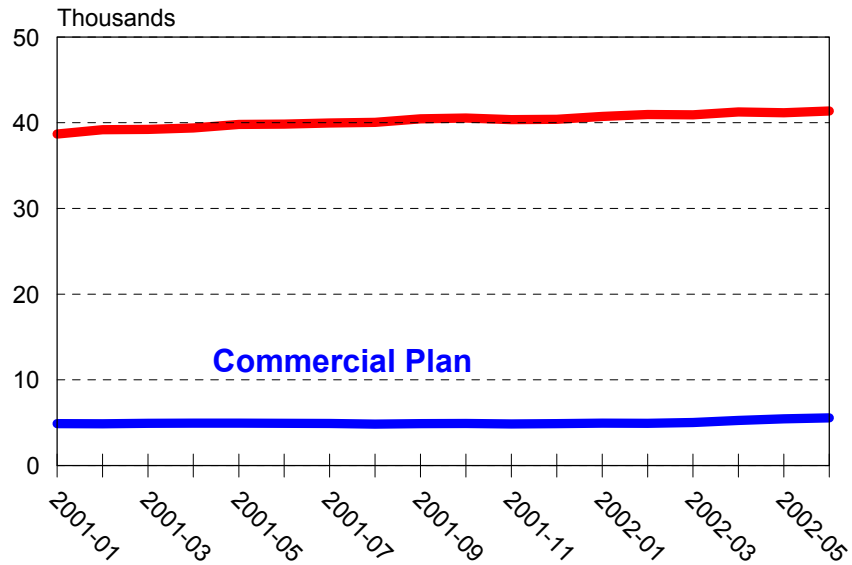
Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File, using a six-month lag.

Table 1.4, Enrollment for Two-Plan Counties (continued)

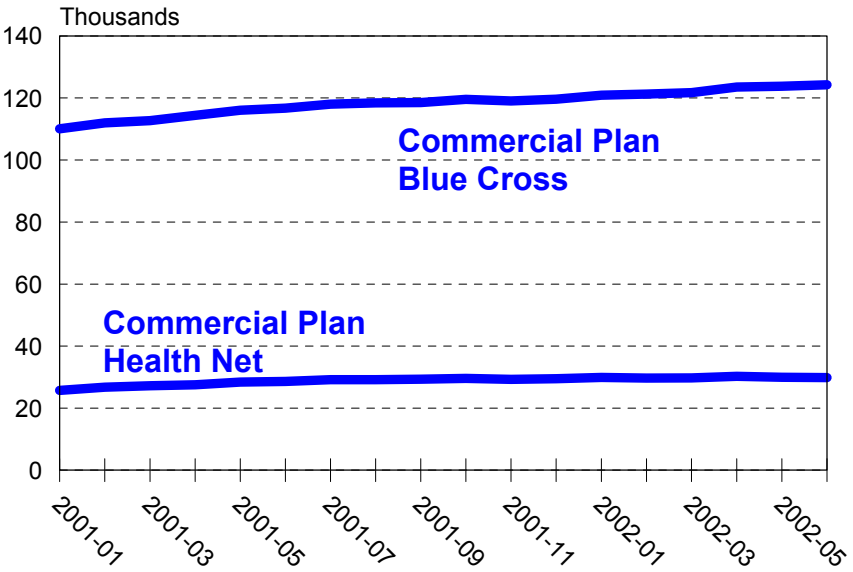
Alameda County



Contra Costa County



Fresno County



Kern County

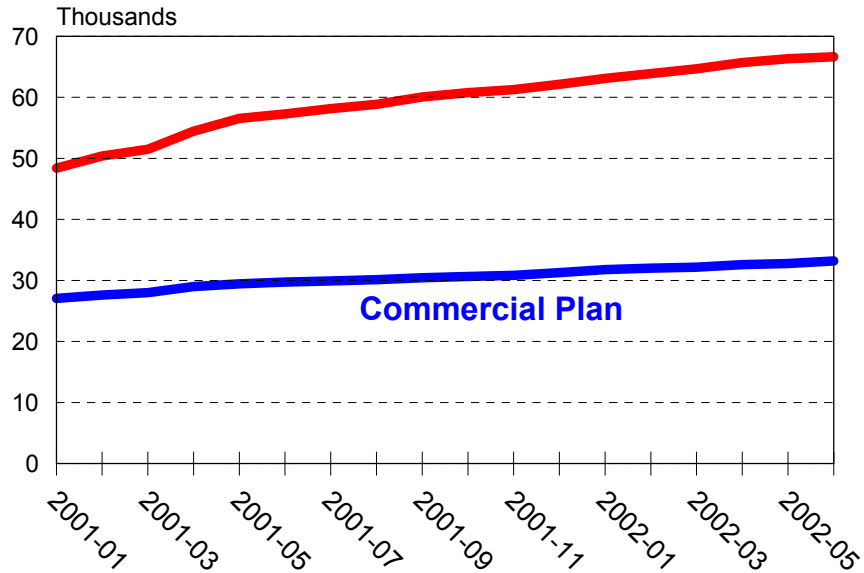
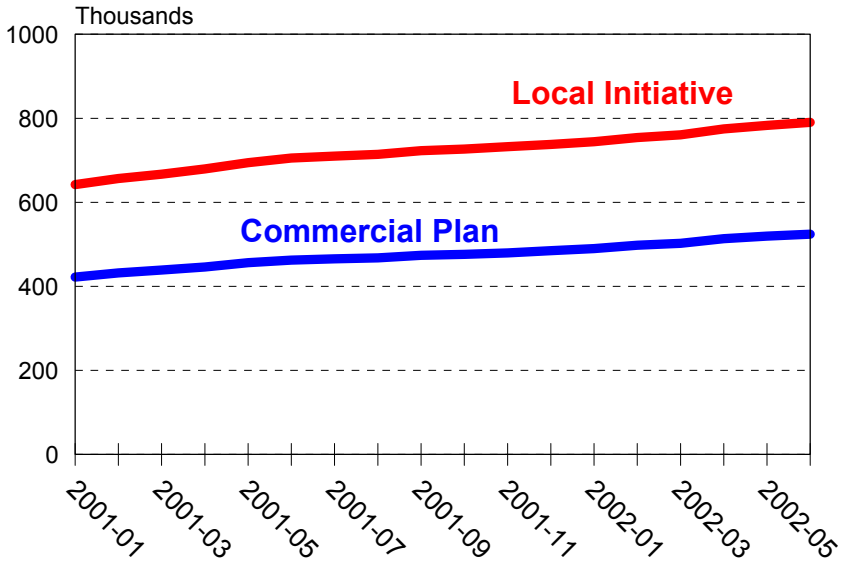
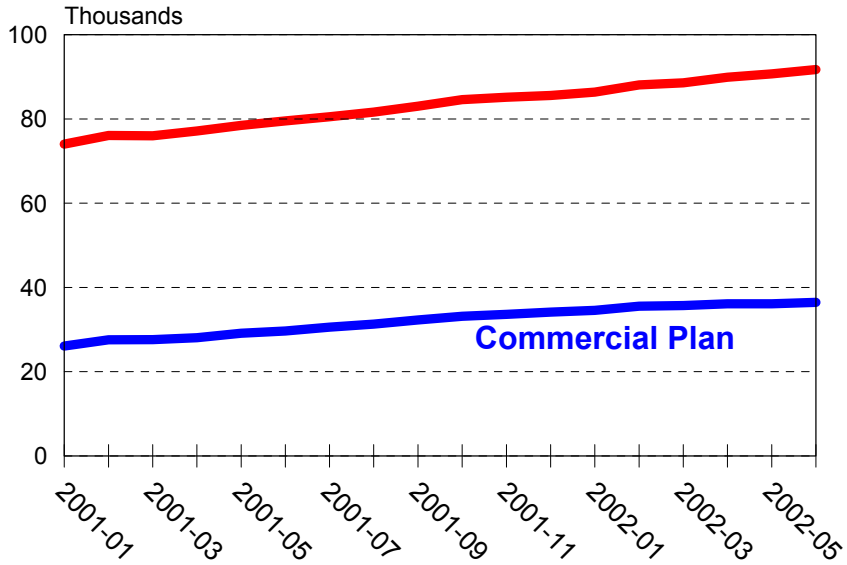


Table 1.4, Enrollment for Two-Plan Counties (continued)

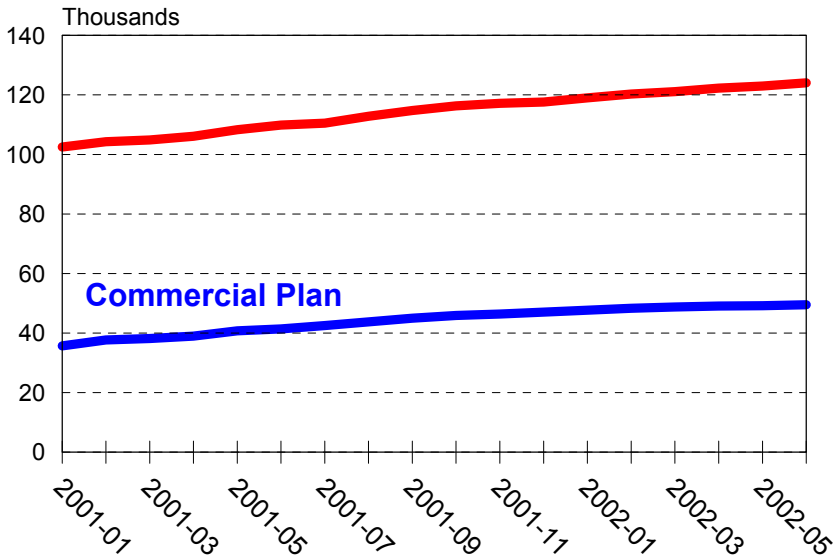
Los Angeles County



Riverside County



San Bernardino County



San Francisco County

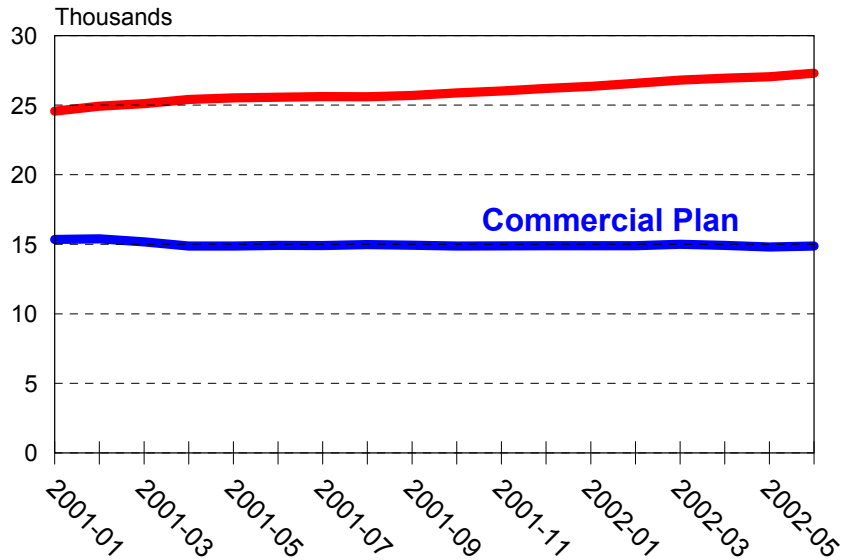
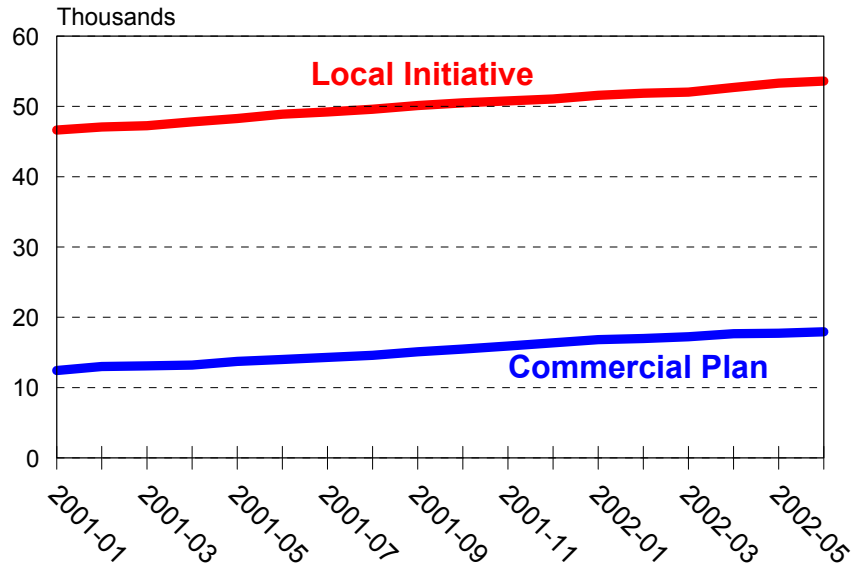
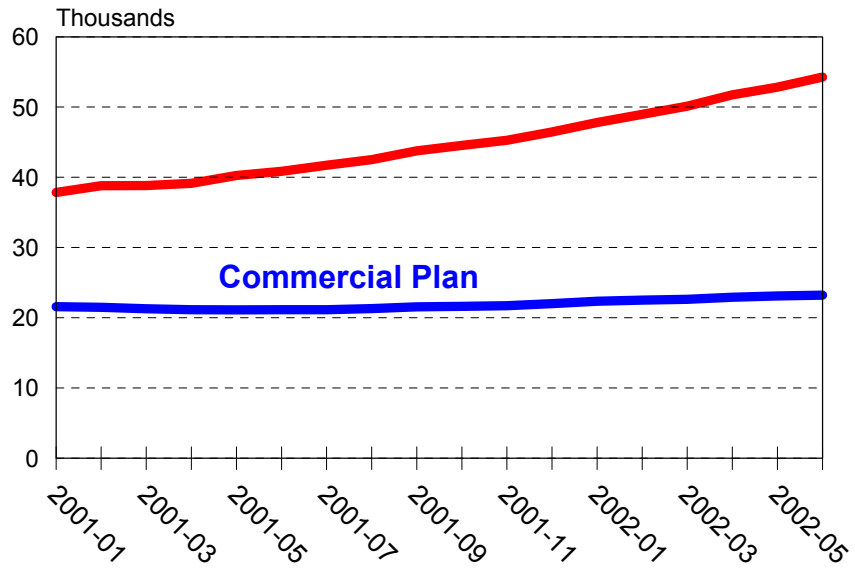


Table 1.4, Enrollment for Two-Plan Counties (continued)

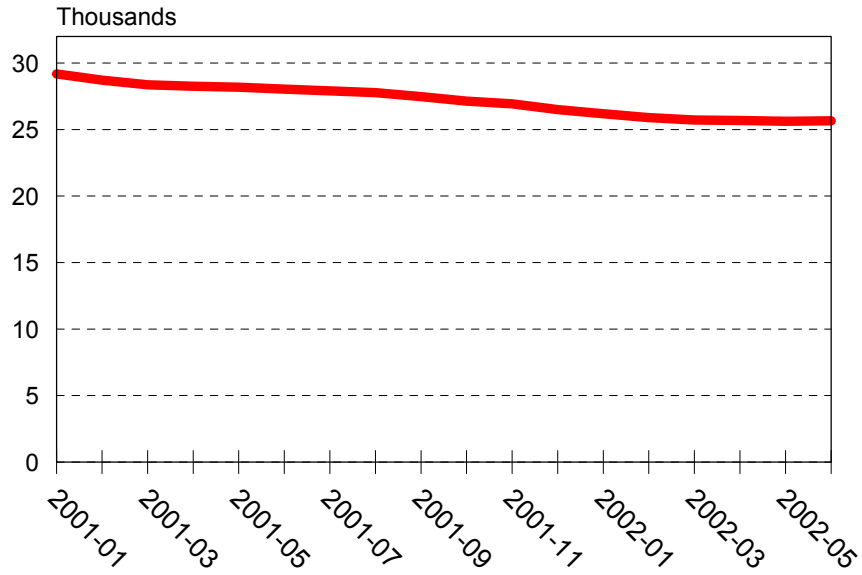
San Joaquin County



Santa Clara County



Stanislaus County



Tulare County

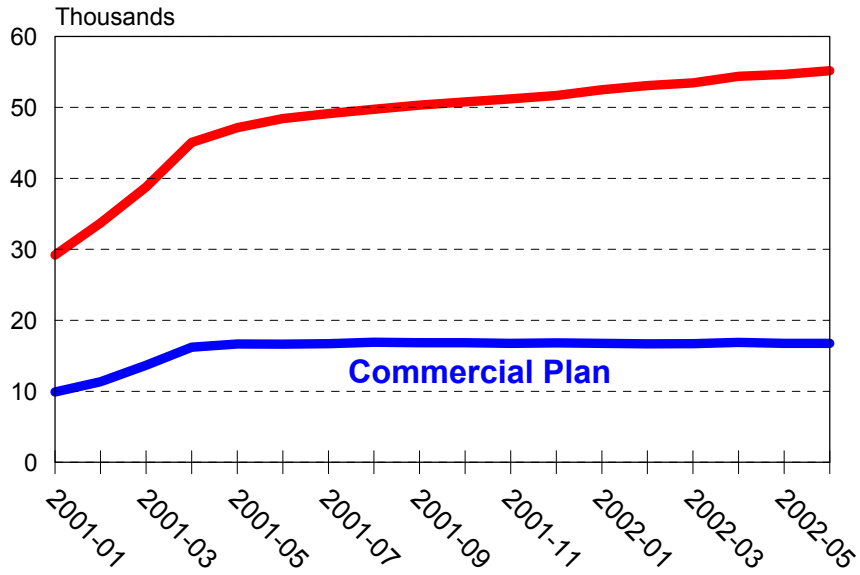


Table 1.5, Monthly Enrollment for GMC Counties

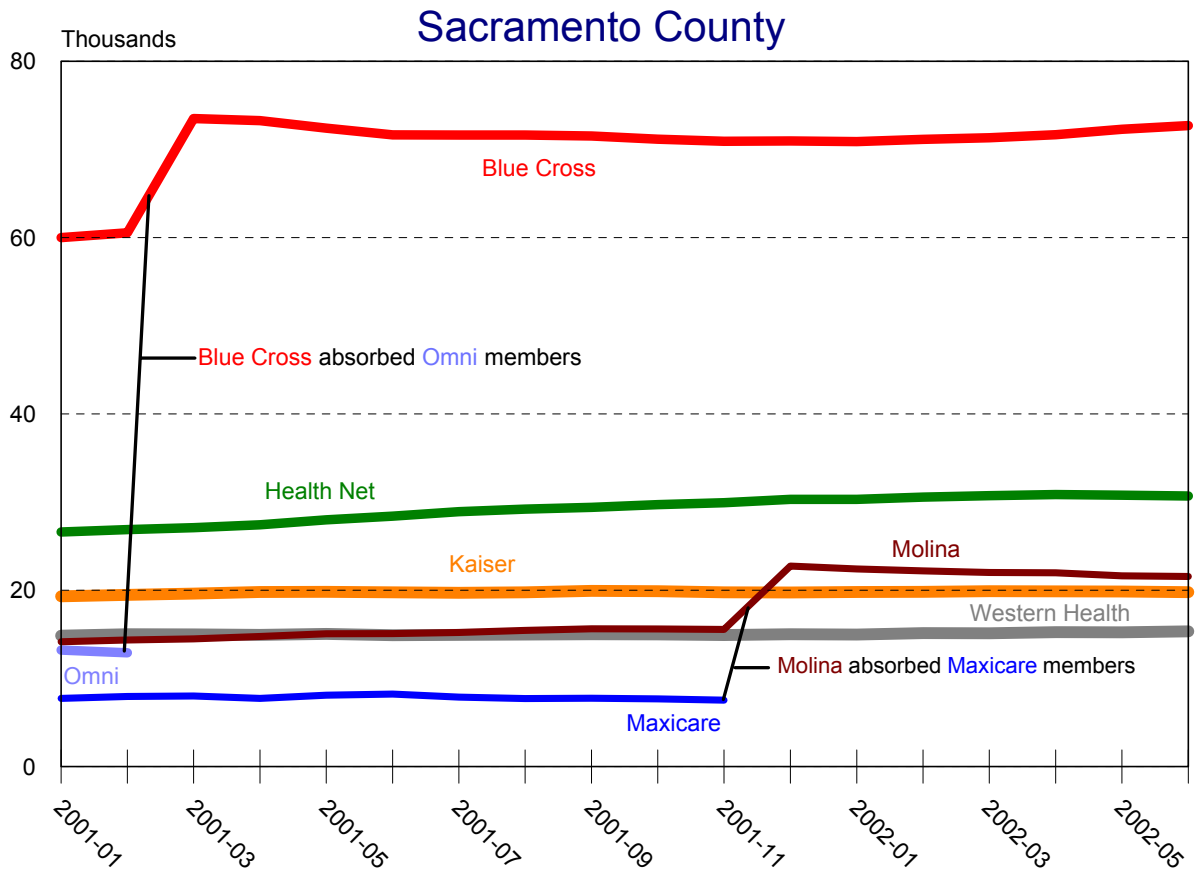
The following charts depict enrollment by county for the individual GMC health plans for January 2001 thru June 2002.

Most Sacramento GMC plans have had steady monthly enrollment since before January 2001 (see the Managed Care Annual Statistical Report published March 2002). Of the five Sacramento GMC plans, Blue Cross has shown the highest enrollment since January 2001, averaging 45% of the Sacramento GMC population.

Currently, there are seven GMC plans in operation in the Healthy San Diego GMC program. The Community Health Group and the Sharp Health plans represent 67% of the Health San Diego population. The remaining five plans (Universal, Blue Cross, UCSD, Inland Empire, and Kaiser) represent a combined enrollment of 33%

Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File, using a six-month lag.

Table 1.5, Monthly Enrollment for GMC Counties (continued)



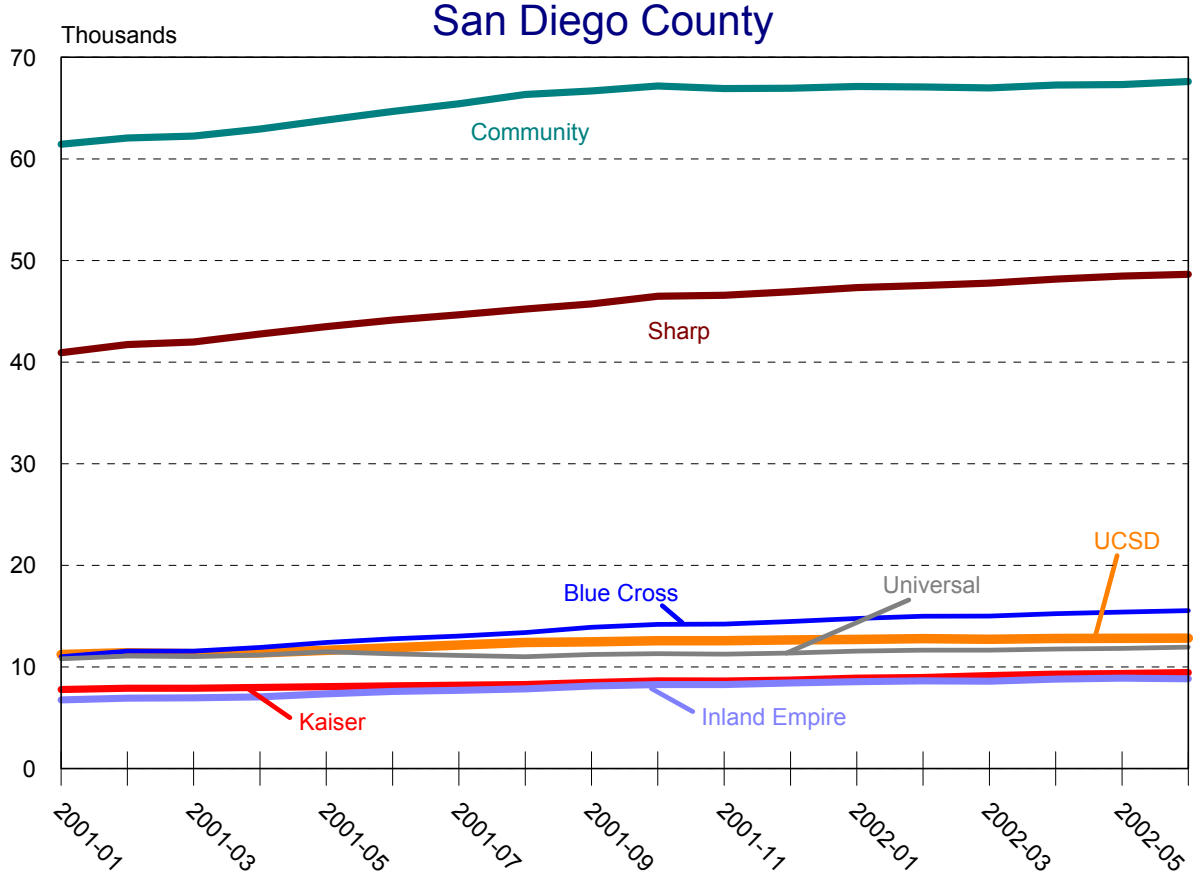
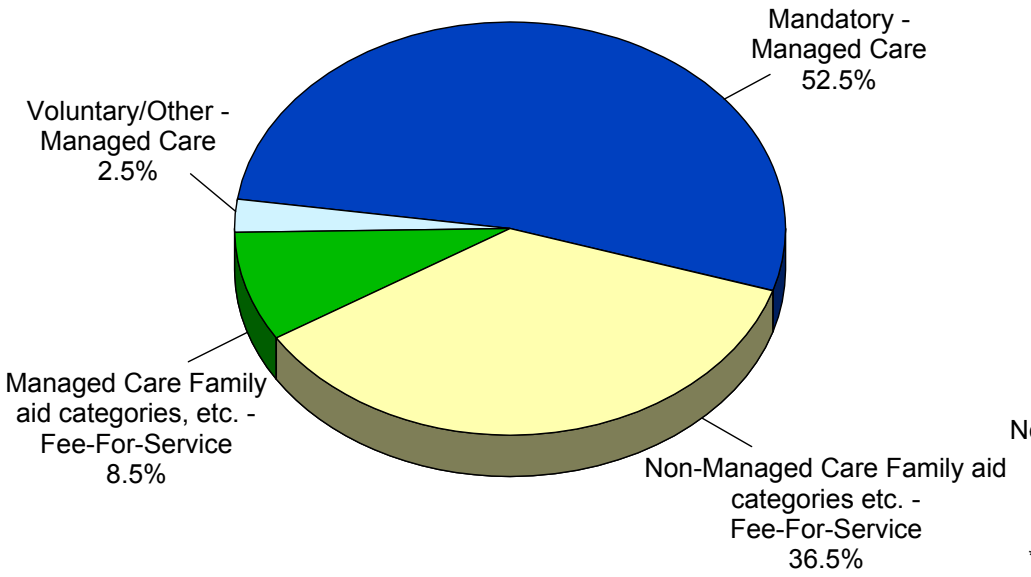


Table 1.6, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties

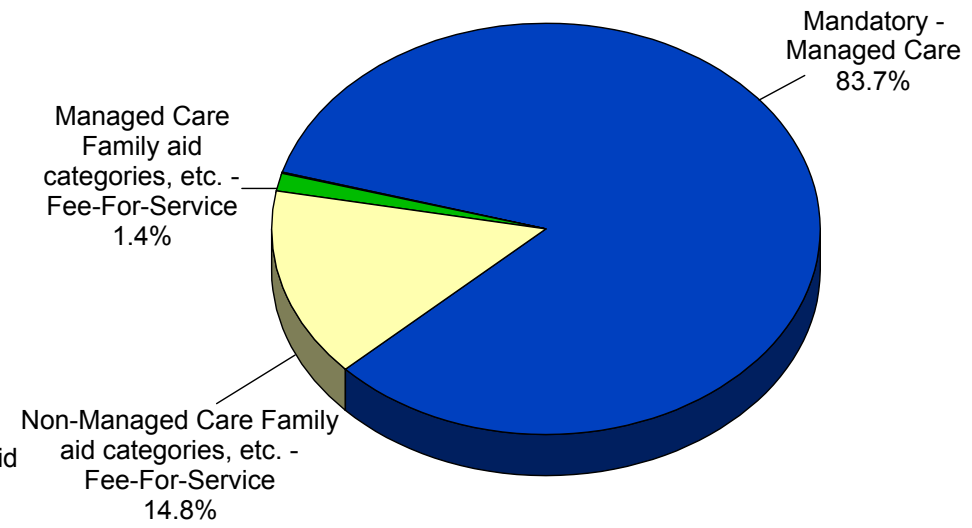
The following pie charts show the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. FFS and mandatory vs. voluntary/other aid category group, for counties implemented to managed care as of July 2002. (See Table 1.7 for a list of these counties.) As this indicates, the percent of those in managed care is 55% (2.5% + 52.5%) for the Two-Plan and GMC counties and 83.8% (0.1% + 83.7%) for the COHS counties for all aid categories. The COHS mandatory managed care population will always be larger than that of the Two-Plan and GMC models since virtually all Medi-Cal beneficiaries in the county must belong to the COHS. For a more detailed description of the COHS plans, please see Section 1.2, Description of Medi-Cal Managed Care, County Organized Health Systems of this report. (See Appendix, Table A.1 for definitions of the aid category groupings.)

Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File, using a six-month lag.

Two-Plan and GMC Counties
Eligibles in Fee-For-Service and Managed Care
Percent Mandatory (Managed Care Family aid categories, etc.) vs.
Voluntary/Other (Non-Managed Care Family aid categories, etc.)



COHS Counties
Eligibles in Fee-For-Service and Managed Care
Percent Mandatory (Managed Care Family aid categories, etc.) vs.
Other* Aid Group (Non-Managed Care Family aid categories, etc.)

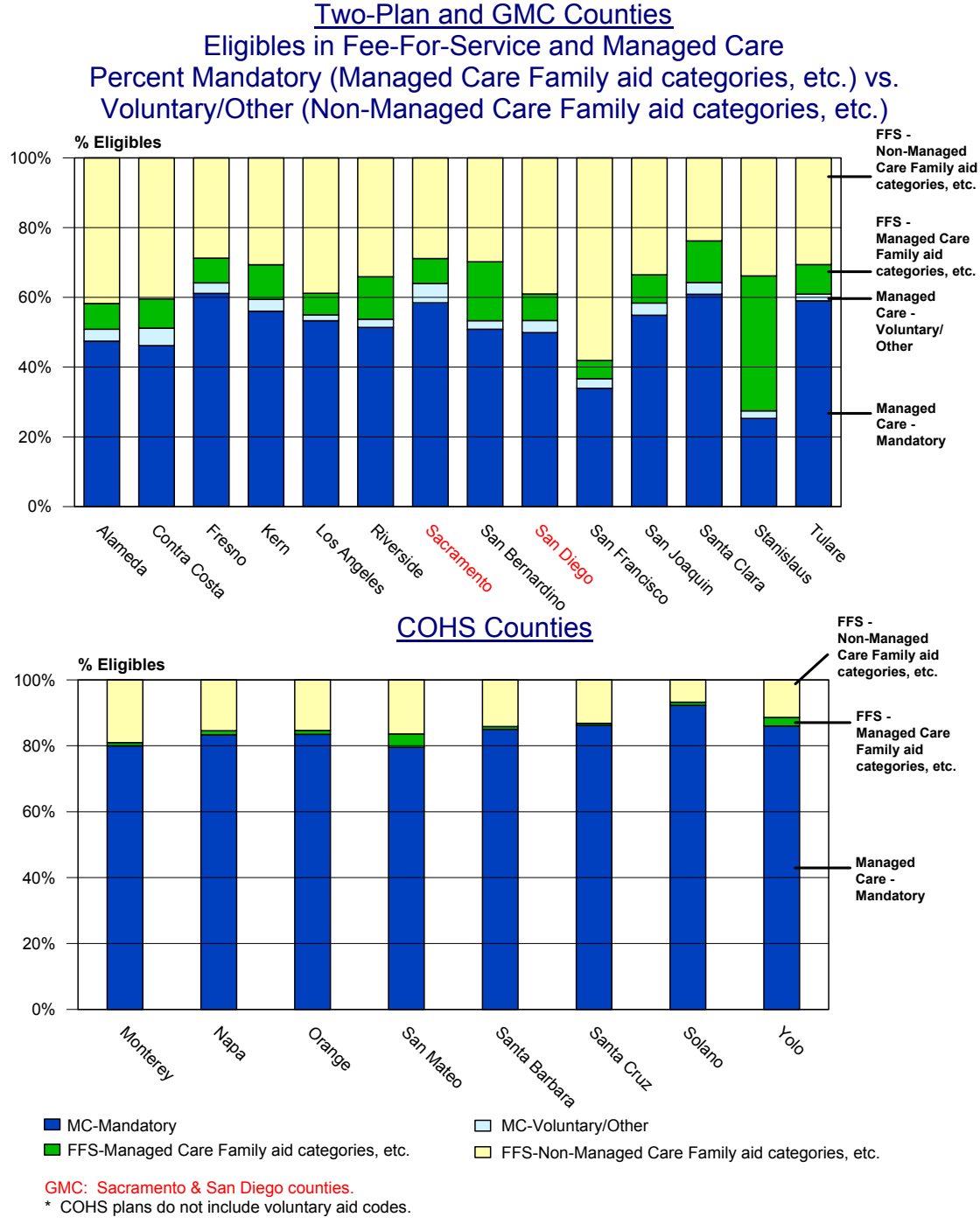


* COHS plans do not include voluntary aid codes. The Other Aid Group for Managed Care eligibles is 0.1%

Table 1.7, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties

The following bar chart provides the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. FFS, and mandatory vs. voluntary/other aid category group (four aid categories in all), for counties implemented to managed care as of July 2002. The chart shows that in most counties over 40% of these beneficiaries are in managed care. The commercial plan in Stanislaus county ceased operations in March 2000; as a result, beneficiaries in mandatory aid codes could elect to enroll into the remaining local initiative or FFS. If a beneficiary did not make a selection they were defaulted into the local initiative. (See Appendix, Table A.1 for definitions of the aid category groupings.)

Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File using, a six-month lag.



GMC: Sacramento & San Diego counties.
* COHS plans do not include voluntary aid codes.

Table 1.8, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles in GMC and Two-Plan Model Counties Only

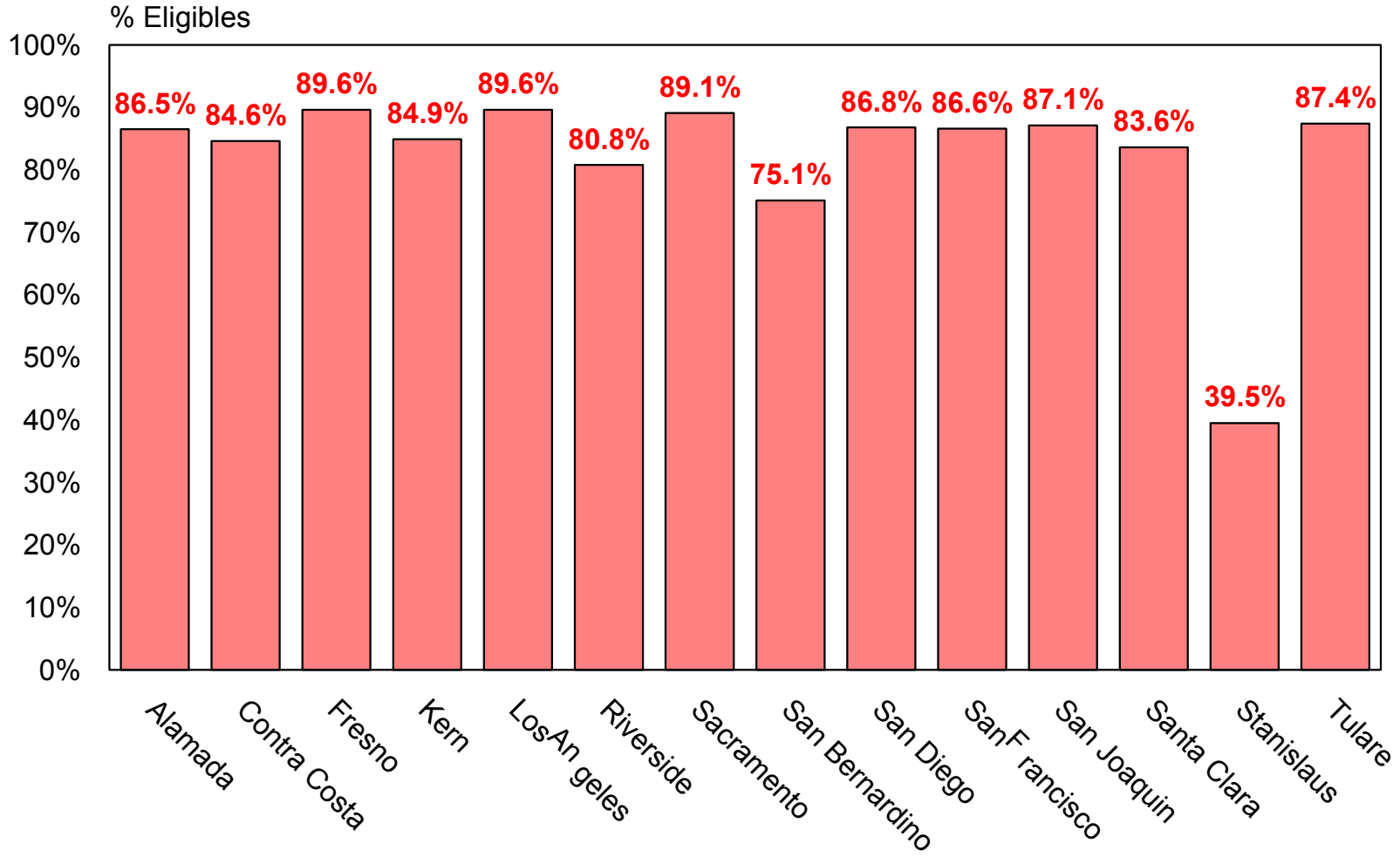
Of those eligibles in a mandatory aid category, the following chart shows the percent of those actually enrolled in a Two-Plan model or GMC managed care plan by county. Overall, there has been no significant change since July 2001 (see the Managed Care Annual Statistical Report published March 2002).

Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File, using a six-month lag.

The percent of beneficiaries in a mandatory aid category enrolled in managed care is always less than 100%. Not every beneficiary in a mandatory aid category will end up in a managed care plan. Reasons for this include:

1) managed care implementation is still in process;
2) the beneficiary received Medi-Cal eligibility retroactively (that is, between the start of the eligibility month and some months later);
3) the beneficiary has other health coverage (usually CHAMPUS, Medicare HMO, Kaiser, or some PHP/HMO and Exclusive Provider Option coverage) that excludes them from enrolling in a plan;
4) the beneficiary just became eligible for Medi-Cal in a particular county, and is still in the process of selecting a plan or will be defaulted into one;
5) the beneficiary lives in an exempted zip code;
6) the beneficiary has a medical exemption granted by the DHS (for a complete list of these exemptions, contact the DHS Medi-Cal Managed Care Division);
7) a person born to a mother on managed care is covered under FFS the month of delivery and the following month, and then is put into managed care only after the parents(s)/legal guardian(s) successfully completes the Medi-Cal enrollment process (usually three to six months after birth);
8) a person switches from a non-mandatory to a mandatory aid code and is still in the process of selecting a plan;
9) in the case of Stanislaus county, the commercial plan ceased operations in March 2000; as a result, beneficiaries in mandatory aid codes could elect to enroll into the remaining local initiative or FFS. If a beneficiary did not make a selection they were defaulted into the local initiative.

Table 1.8, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles in GMC and Two-Plan Model Counties Only (continued)



Section 2, Demographic Characteristics

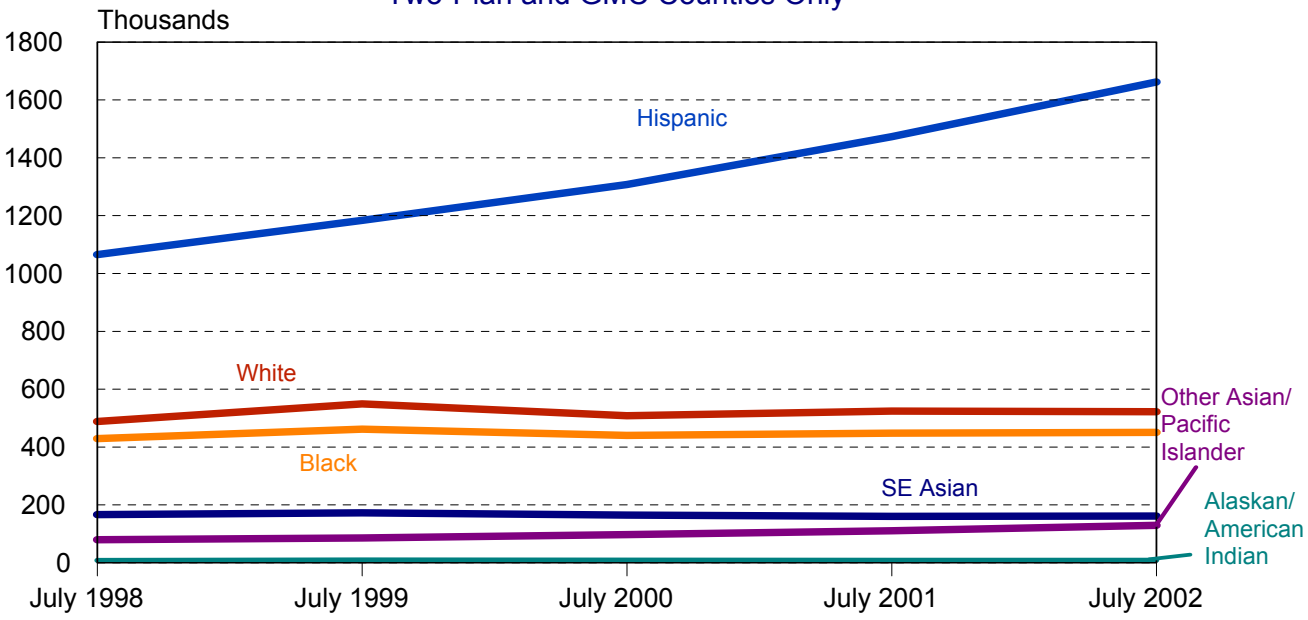
This section provides an analysis of the Medi-Cal managed care population by such demographic characteristics as ethnicity (Table 2.1), language (Table 2.2), and age and gender (Tables 2.3 & 2.4). Table 2.5 provides breakouts by age and gender for the managed care Two-Plan and GMC counties versus FFS.

Table 2.1, Breakout of Eligibles by Major Ethnic Category in Two-Plan and GMC Counties

The following charts show a distribution of the Medi-Cal eligible population in managed care, GMC and Two-Plan counties by major ethnic category. The first chart shows this breakout for the population considered Mandatory (Managed Care Family aid categories, etc.). The second chart covers those not in a Mandatory (Non-Managed Care Family aid categories, etc.) aid category group.

Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File, using a four-month lag and the Managed Care Annual Statistical Reports published in 1999, 2000, 2001, and 2002.

Mandatory (Managed Care Family aid categories, etc.) Eligibles
By Major Ethnic Group and Month of Eligibility
Two-Plan and GMC Counties Only



Non-Mandatory (Non-Managed Care Family aid categories, etc.) Eligibles

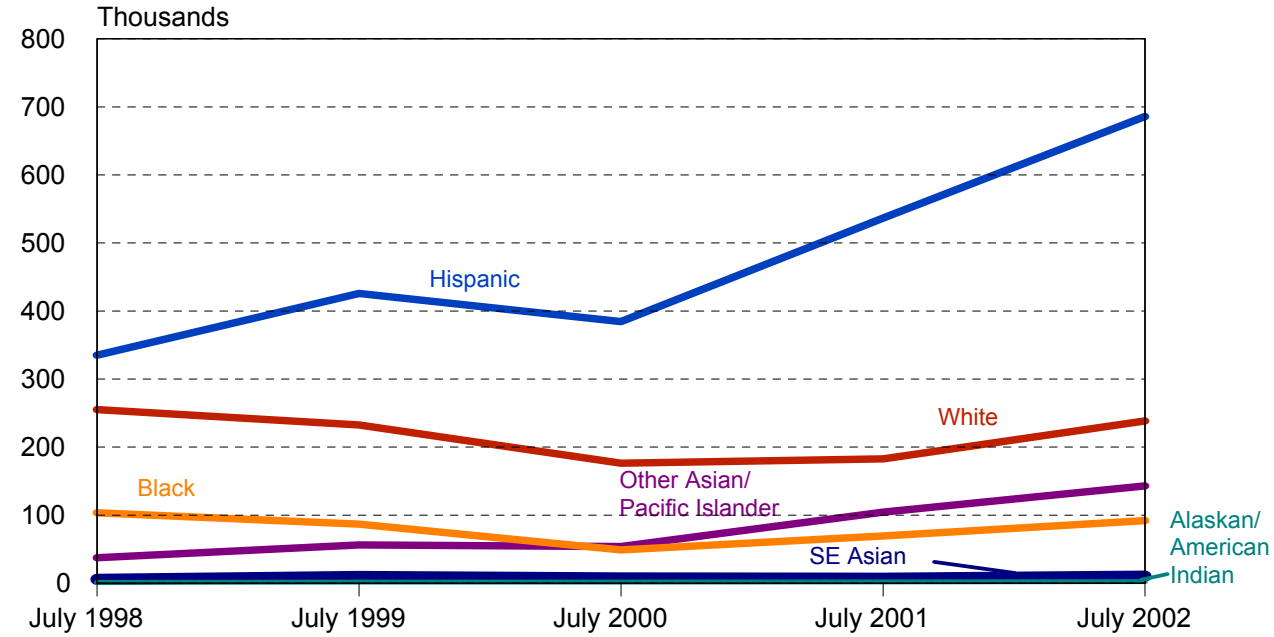
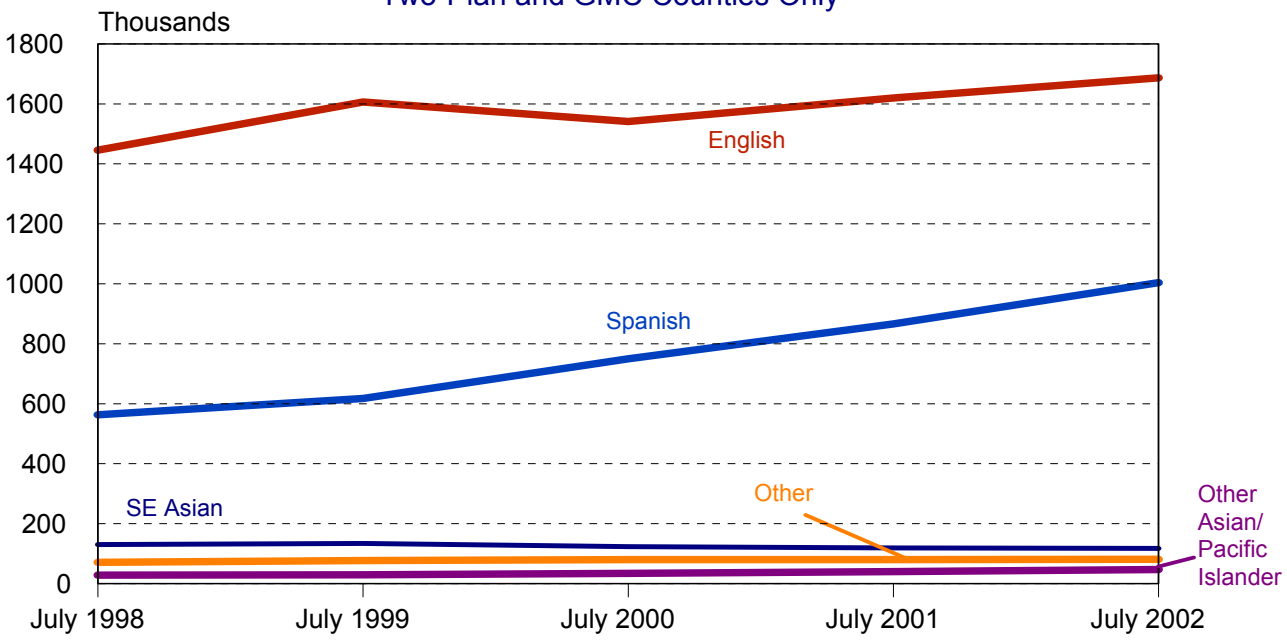


Table 2.2, Breakout of Eligibles by Major Language Category in Two-Plan and GMC Counties

The following charts show a distribution of the Medi-Cal eligible population in managed care, GMC and Two-Plan counties by major language category. The first chart shows this breakout for the population considered Mandatory (Managed Care Family aid categories, etc.). The second chart covers those not in a Mandatory (Non-Managed Care Family aid categories, etc.) aid category group.

Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File, using a four-month lag and the Managed Care Annual Statistical Reports published in 1999, 2000, 2001, and 2002.

Mandatory (Managed Care Family aid categories, etc.) Eligibles
By Major Language Category and Month of Eligibility
Two-Plan and GMC Counties Only



Non-Mandatory (Non-Managed Care Family aid categories, etc.) Eligibles

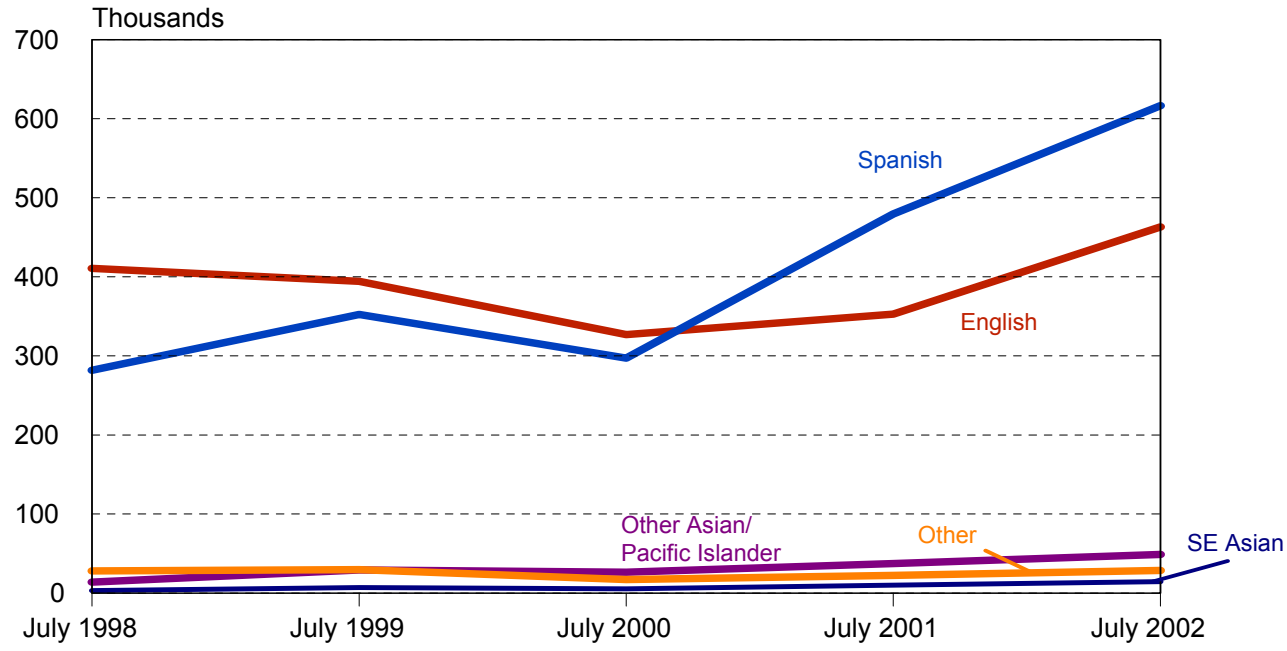


Table 2.3, Managed Care Enrollment by Age and Gender for Two-Plan and GMC County Eligibles

To understand the medical needs of the Medi-Cal population, it is helpful to know their distribution by age, gender and coverage by managed care. The chart below provides a breakout of those enrolled in managed care, by age and gender, for the Two-Plan and GMC counties for all aid codes.

The chart below illustrates that almost 61% of the children, up to twelve months of age, residing in a Two-Plan/GMC county are in managed care This low percent is due to the fact that fewer beneficiaries less than one year of age are in mandatory aid codes. The chart also illustrates that the percent of beneficiaries in a managed care plan remains stable for the female population, but rises briefly (to 66%) for eighteen-year-old males before declining to a more stable 33% for twenty-five-year-olds.

Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File, using a six-month lag; all ages are rounded off.

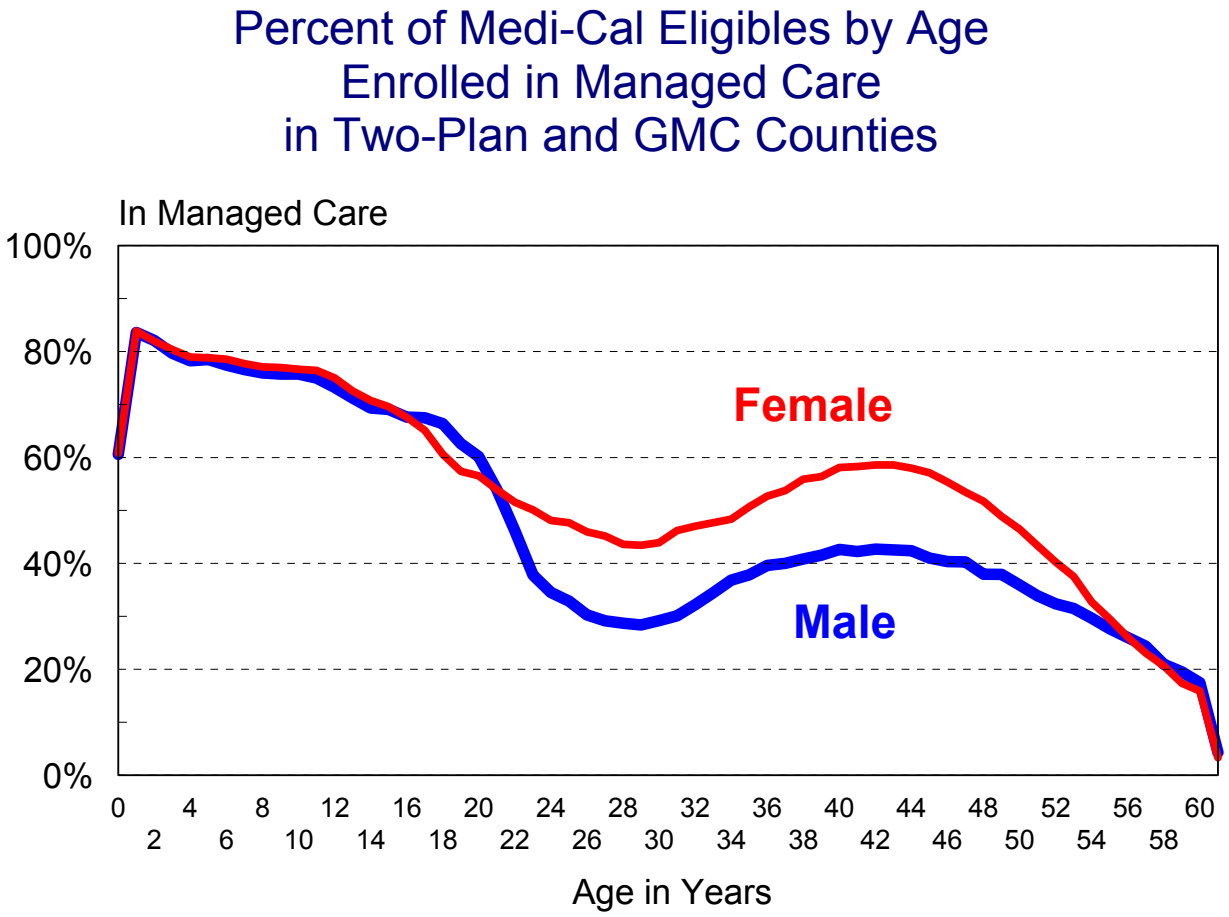


Table 2.4, Two-Plan and GMC County Managed Care Eligibles by Age Category

The following chart provides the number of eligibles in a Two-Plan or GMC plan by age, expressed as a percent. As this chart shows, the "19 years of age or over" category and the "six years of age or less" category each reflect almost a third of the Two-Plan and GMC population. The chart also shows that children, less than 19 years old, represent 69% of the Two-Plan and GMC population. These percentages do not change dramatically from year to year. In fact, they have not changed at all since July 2001 (see the Managed Care Annual Statistical Report published March 2002).

Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File, using a six-month lag.

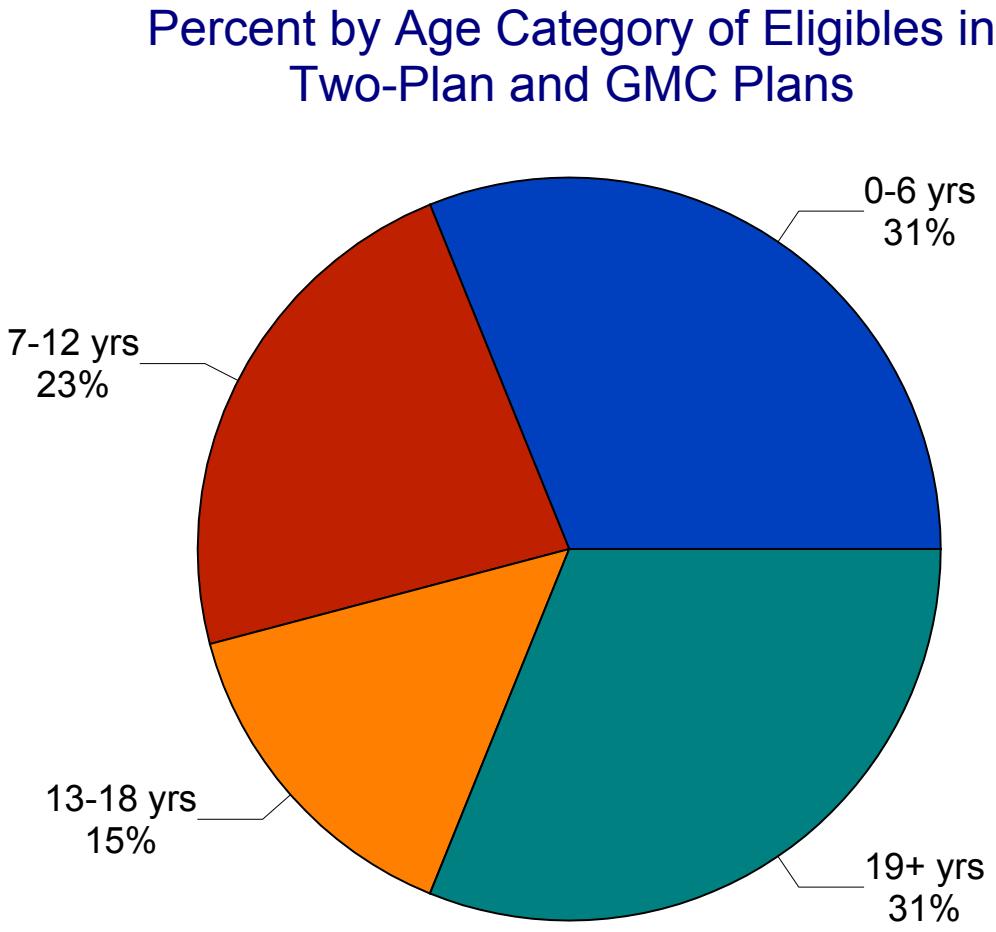
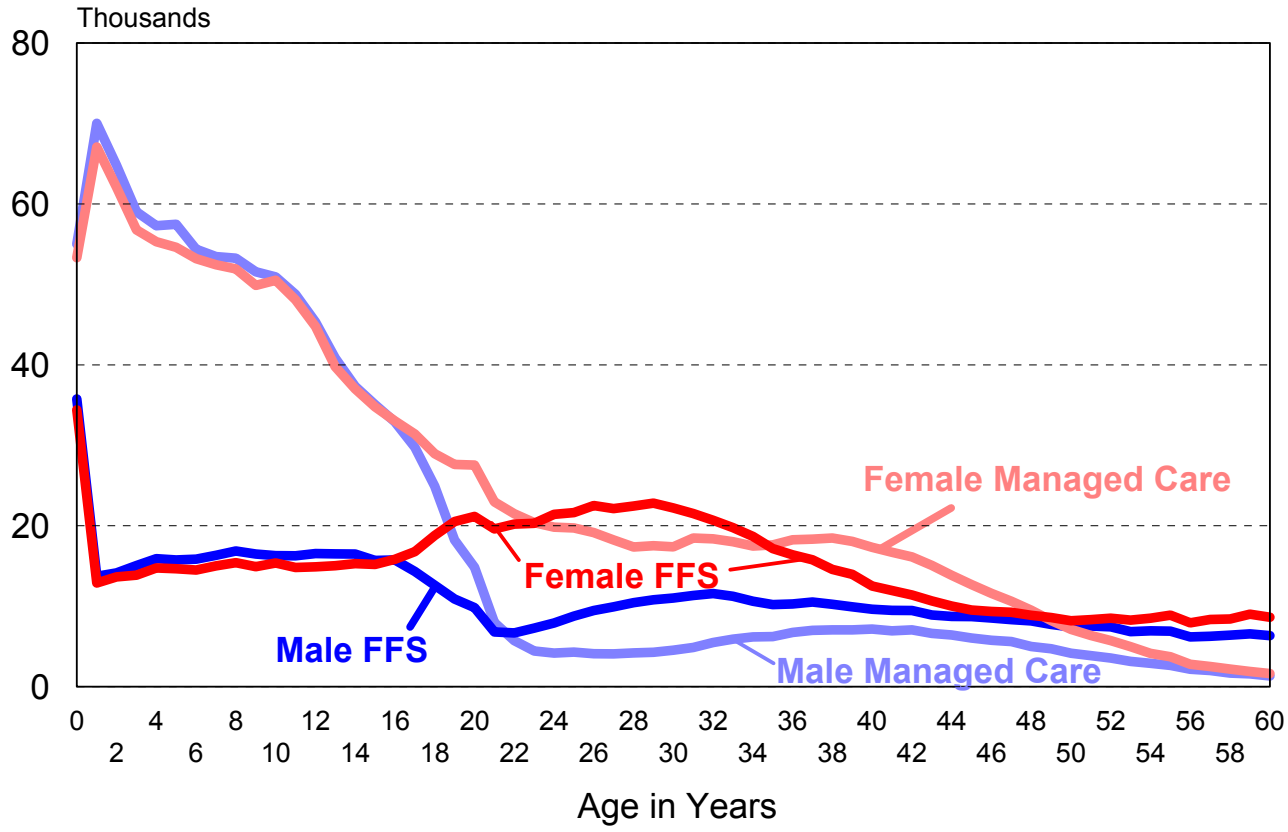


Table 2.5, Medi-Cal Eligibles Enrolled in FFS vs. Managed Care in Two-Plan and GMC Counties, by Age

The following chart provides the number of beneficiaries in FFS and managed care for the Two-Plan and GMC counties by age. As reflected in Table 2.3, the number of males in both managed care and FFS drops sharply at about 18 years of age. The number of males in managed care equals the number in FFS at about age 21, whereas the number of females in managed care versus FFS is about the same at ages 23 and 35, and again at age 49. Historically, the number of adult males on Medi-Cal is always less than the number of females.

Source of these data is the July 2002 month of eligibility Medi-Cal Eligibles File, using a six-month lag; all ages are rounded off.

Number of Medi-Cal Eligibles in FFS vs. Managed Care in Two-Plan and GMC Counties, by Age



Section 3, Eligibility Patterns

The length of time someone is enrolled in Medi-Cal is an important factor in the provision of medical services under managed care. The longer and more continuously a person is enrolled in a managed care plan, the easier it should be for a beneficiary to receive preventive and continuous care.

One useful measure for quantifying member satisfaction by the Medi-Cal population with their plan is the rate at which beneficiaries stay in a managed care plan. One measure of this is the number of continuously-enrolled beneficiaries moving from one plan to another, expressed as a percent of all enrollees who start out in that plan in a given month. This rate was derived for the Local Initiative and Commercial Two-Plan model plans and the GMC plans, and is depicted in Table 3.1.

Another approach to measuring Medi-Cal managed care enrollee stability is to quantify the rate of beneficiary disenrollments from managed care plans. Table 3.2 shows Two-Plan Model disenrollment rates by reason for disenrollment.

Note: Data for Tables 3.1 were derived from a longitudinal database for a 100 percent sample of all Medi-Cal beneficiaries, created and maintained by the CDHS/MCSS. Data for Table 3.2 was derived from reports issued by the DHS Health Care Options contractor, Maximus.

Table 3.1, Continuity of Enrollment for Two-Plan and GMC Model Plans

Measuring continuity of eligibility is an indirect way of quantifying member satisfaction with their managed care plan, based on the assumption that dissatisfied members would switch plans, thereby contributing to overall lower plan retention rates.

The following table shows the rates at which Medi-Cal beneficiaries in the various plans are continuously enrolled in a managed care plan, by model, over a sliding eighteen-month period, with the six starting months of August 2002 through December 2002. The methodology used to compute these "attrition curves" was first to start with all beneficiaries continuously enrolled for eighteen months in one of these model plans, starting with the month of December 2002 (month = "01"), then follow this group backwards in time for up to eighteen months. (The counties of Fresno, Stanislaus and Tulare were excluded inasmuch as they did not have both a commercial and local initiative plan in place for these periods; also excluded was plan 130, Molina/Sacramento, which absorbed Maxicare members in late 2001.) At any time before the first month that the beneficiary was no longer enrolled in that plan, they were not counted. Then the cohort for the starting month of November 2002 was tracked backwards for up to eighteen months to obtain attrition counts, and so on through the starting month of August 2002. All counts by month were then aggregated and expressed as a percent of the starting month count.

As shown below, GMC plans have the highest rates of attrition, followed by the Commercial Plans. One contributing factor to the GMC's lower rates of retention might be that there are more plans for the beneficiary to choose from (five in Sacramento, seven in San Diego).

Table 3.1, Continuity of Enrollment for Two-Plan and GMC Model Plans (continued)

Source for these data is a one hundred percent (100%) longitudinal Medi-Cal eligibility file maintained by the California Department of Health Services, Medical Care Statistics Section.

Continuity of Enrollment for Two-Plan and GMC Model Plans for Continuously Enrolled Beneficiaries

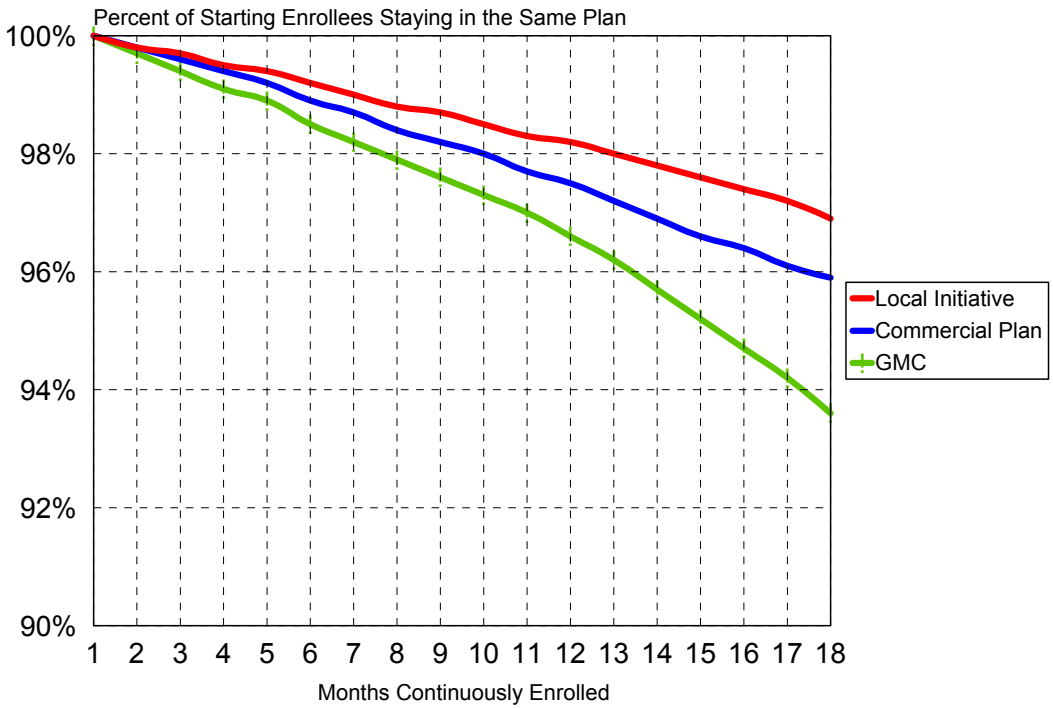


Table 3.2, Rate of Disenrollments from Two-Plan and GMC Model County Plans

Another indirect way to look at member satisfaction with a plan is to determine the rate of beneficiary disenrollments from each of the plans. To derive these counts, the number of members disenrolled from each GMC and Two-Plan Model health care plan was obtained from monthly reports from the health care options contractor, Maximus, for the six months of January through June 2002. (The counties of Fresno, Stanislaus and Tulare were excluded inasmuch as they did not have both a commercial and local initiative plan in place.) These counts were then divided by the count of monthly members in each of the three plan types shown below and their rates then converted to counts per 1,000 beneficiaries.

As the table shows, beneficiaries in GMC plans disenroll at the highest overall rate, but only marginally higher than for the Commercial plans. Since beneficiaries in GMC counties have several plans to choose from, a slightly higher rate of switching plans (see first reason listed below) might be expected. As with the attrition rates for continuity of plan membership (see Table 3.1, above), Local Initiative plans show the lowest rates. This appears consistent with the data in Table 1.4, Enrollment for Two-Plan Counties, which generally show higher rates of increased enrollment for Local Initiative plans versus Commercial plans.

Table 3.2, Disenrollment Rates per 1000 Beneficiaries for GMC and Two-Plan Model Plans, by Reason

Prepared by the California Department of Health Services

	Plan Type		
Reason	**GMC**	**Local Initiative**	**Commercial**
Beneficiary preference/Health plan did not meet needs/Beneficiary did not identify a disenrollment reason code	4.50	2.14	4.84
Did not choose plan	0.45	0.08	0.20
Could not choose doctor	0.39	0.09	0.21
Doctor did not meet beneficiary's needs	0.19	0.06	0.13
Too far to go	0.12	0.03	0.07
Medical exemption	0.03	0.05	0.08
Moved out of county	0.00	0.00	0.00
Other	0.12	0.08	0.22
Overall	**5.80**	**2.52**	**5.75**

Source: MSC-B-M05 report, produced by Maximus, under contract with the California Department of Health Services.

Appendices

Appendix, Table A.1 List of Aid Categories by Managed Care Model and Type of Membership Status

Prepared by the California Department of Health Services

The following table provides a list of aid categories that are considered mandatory (M), vs. voluntary (V), vs. other (o) [can't join] for each plan model. (Note: This table was current as of May 2001. For a current table, contact the DHS Medi-Cal Managed Care Division.)

Note: These are the aid code categories that were in effect as of June 2002.

	COHS			GMC	Two-Plan	FFS/ MCN	PHP/ PCCM
Aid Cat.	San Mateo & Solano	Yolo	Monterey, Napa, Orange, Santa Barbara, & Santa Cruz	Sacramento & San Diego			
0A	M	M	M	M	M	V	V
OG	M	M	M	M	M	M	M
OM	M	M	M	V	V	V	V
ON	M	M	M	V	V	V	V
OP	M	M	M	V	V	V	V
OU	M	M	M	V	V	V	V
OT	M	M	M	V	V	V	V
OR	M	M	M	V	V	V	V
01	M	M	M	M	M	V	V
02	M	M	M	M	M	M	V
03	M	M	M	V	V	V	V
04	M	M	M	V	V	V	V
08	M	M	M	M	M	V	M
10	M	M	M	V	V	V	V
13	M	M	M	o	o	o	o
14	M	M	M	V	V	V	V
16	M	M	M	V	V	V	V
17	M	M	M	o	o	o	o
18	M	M	M	V	V	V	V
1H	M	M	M	V	V	V	V
20	M	M	M	V	V	V	V
23	M	M	M	o	o	o	o
24	M	M	M	V	V	V	V
26	M	M	M	V	V	V	V
27	M	M	M	o	o	o	o
28	M	M	M	V	V	V	V
30	M	M	M	M	M	M	V
32	M	M	M	M	M	M	V
33	M	M	M	M	M	M	V
34	M	M	M	M	M	M	V
35	M	M	M	M	M	M	V
36	M	M	M	V	V	V	V
37	M	M	M	o	o	o	o
38	M	M	M	M	M	M	V
39	M	M	M	M	M	M	V
3A	M	M	M	M	M	M	V
3C	M	M	M	M	M	M	V
3E	M	M	M	M	M	M	V
3G	M	M	M	M	M	M	V
3H	M	M	M	M	M	M	V
3L	M	M	M	M	M	M	V
3M	M	M	M	M	M	M	V
3N	M	M	M	M	M	M	V
3P	M	M	M	M	M	M	V
3R	M	M	M	M	M	M	V
3U	M	M	M	M	M	M	V
3W	M	M	M	M	M	M	V
40	M	M	M	V	V	V	V
42	M	M	M	V	V	V	V
45	M	M	M	V	V	V	V

Appendix, Table A.1 List of Aid Categories by Managed Care Model and Type of Membership Status

	COHS			GMC	Two-Plan	FFS/ MCN	PHP/ PCCM
Aid Cat.	San Mateo & Solano	Yolo	Monterey, Napa, Orange, Santa Barbara, & Santa Cruz	Sacramento & San Diego			
47	M	M	M	M	M	M	V
4A	M	M	M	V	V	V	V
4C	M	M	M	V	V	o	V
4F	M	M	M	V	V	V	V
4G	M	M	M	V	V	V	V
4K	M	M	M	V	V	o	V
4M	M	M	M	V	V	V	V
53	M	M	M	o	o	o	o
54	M	M	M	M	M	M	V
55	M	o	o	o	o	o	o
58	M	o	o	o	o	o	o
59	M	M	M	M	M	M	V
5F	M	o	o	o	o	o	o
5G	M	o	o	o	o	o	o
5K	M	M	M	V	V	V	V
5N	M	o	o	o	o	o	o
5X	M	M	M	M	M	M	V
60	M	M	M	V	V	V	V
63	M	M	M	o	o	o	o
64	M	M	M	V	V	V	V
65	M	M	M	o	o	o	o
66	M	M	M	V	V	V	V
67	M	M	M	o	o	o	o
68	M	M	M	V	V	V	V
6A	M	M	M	V	V	V	V
6C	M	M	M	V	V	V	V
6H	M	M	M	V	V	V	V
6J	M	M	M	V	V	V	V
6N	M	M	M	V	V	V	V
6P	M	M	M	V	V	V	V
6R	M	M	M	V	V	V	V
6V	M	M	M	V	V	V	V
6W	M	M	M	o	o	o	o
6X	M	M	M	o	o	o	o
6Y	M	M	M	o	o	o	o
72	M	M	M	M	M	M	M
7A	M	M	M	M	M	M	M
7J	M	M	M	V	V	V	V
7X	M	M	M	M	M	M	V
81	M	M	M	o	o	o	o
82	M	M	M	M	M	V	V
83	M	M	M	o	o	o	o
86	M	M	M	V	V	V	V
87	M	M	M	o	o	o	o
8P	M	M	M	M	M	M	V
8R	M	M	M	M	M	M	V